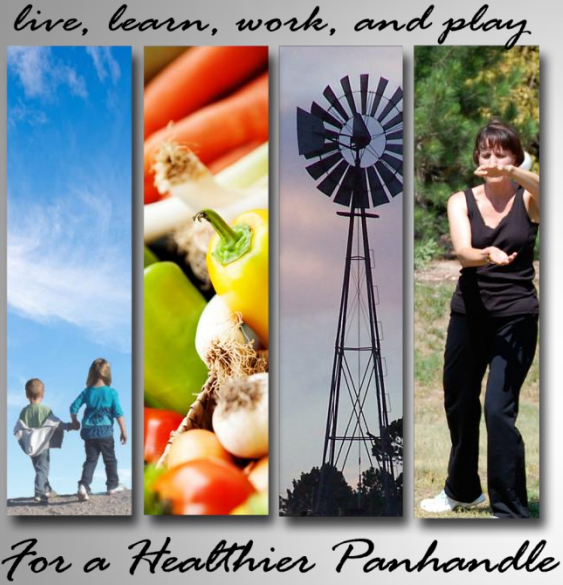
Community Health Assessment



Nebraska Panhandle

Panhandle Public Health District, Scottsbluff County Health Department, Box Butte General Hospital, Chadron Community Hospital, Garden County Health Services, Gordon Memorial Hospital, Kimball Health Services, Morrill County Community Hospital, Regional West Medical Center, Sidney Regional Medical Center

2011

Panhandle Public Health District

Scotts Bluff County Health Department

Dear Panhandle Communities,

Every three to five years we come together in the Panhandle to complete a public health assessment and Community Health Improvement Plan. During 2011 and 2012, people across the region worked collaboratively to review data, share concerns and strengths of our communities, and identify priority areas that we can work on together to improve the health status for all people living in the Panhandle. The planning process used was Mobilizing for Action through Planning and Partnerships (MAPP). The ultimate goal of MAPP is optimal community health – a community where residents are healthy, safe and have a high quality of life.

There are four assessments in the MAPP process, preceded by a vision session and followed by the development of the community health improvement plan. The four assessments are:

- Community themes and strengths – surveys and focus groups to gather public opinion
- Community health status – uniform dataset of leading health indicators
- Forces of change – trends, events and factors that impact health and quality of life
- Local public health system assessment of accessible services

Panhandle Public Health District and Scotts Bluff County Health Department partnered with the hospitals and health systems as well as the rest of the local public health system and did the four assessments and the community health improvement planning together for the good of all 11 Panhandle counties. The public was encouraged to participate throughout the process through surveys, focus groups and participatory planning processes.

The following are the results of the assessments and were used for the preparation of the community health improvement plan. We thank you for your participation, and encourage you to continue to be engaged in helping solve these complex issues.

Sincerely,

Kimberly A. Engel
Director
Panhandle Public Health District

Bill Wineman
Director
Scotts Bluff County Health Department

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Additional Regional Assessments:

Introduction

Panhandle Public Health District and Scotts Bluff County Health Department are always working, along with the entire public health system, to improve the health of the communities they serve. The health departments frequently collaborate with partners to identify performance improvement opportunities, enhance management, develop leadership and strengthen relationships with members of the community.

In early 2011 the Panhandle Public Health District (PPHD) and the Scotts Bluff County Health Department (SBCHD) entered into a collaborative relationship to facilitate a comprehensive community health assessment and planning process for all eleven counties of the Panhandle. This agreement was based on the long established collaborations within the local public health system. It also reflects the understanding of the inter-relationship of broad scale health factors among the nearly 83,000 citizens of these remote rural counties in western NE.

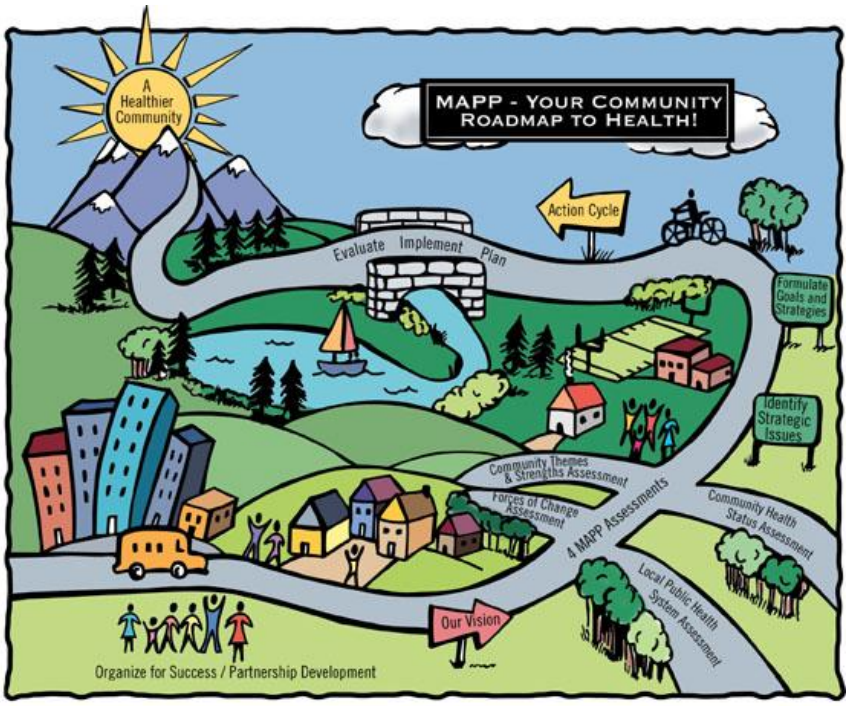
The purpose of the community health improvement plan in the Panhandle is to describe how PPHD, SBCHD and the communities they serve will work together to improve the health of the entire Panhandle. The planning will include a broad set of stakeholders and partners. The planning and implementation process will be entirely community-driven.

The following assessments, processes and resources were used to conduct the assessment and planning process.

Community Health Needs Assessment

Preliminary Steps

The nationally recognized Mobilizing for Action through Planning and Partnership (MAPP) process provided the foundation for the assessment process. The MAPP process included two preliminary steps, Organization and Vision.



Organization
Panhandle Public Health District was charged with the leadership of the project. This role included establishing timely schedules, allocation of personnel resources, contracting for additional services, promotion and media relations, and production of the final report. Both Public Health entities formed a management team to provide oversight and quality assurance to the process.

Local Public Health System Collaborative Infrastructure
The region enjoys a robust well established collaborative infrastructure which provided the foundation for the local public health system communication and engagement process. This infrastructure includes:

- Rural Nebraska Healthcare Network which includes all eight hospitals in the region, all Rural Health Clinics, and Assisted Living/Nursing Homes that are part of the RNHN member systems. This group includes the Trauma Network.
- Public Health Partnerships including collaborative work groups such as the Panhandle Regional Medical Response System (PRMRS), Panhandle Worksite Wellness Council, Cancer Prevention Coalition as well as the two Public Health Boards which include elected officials.
- Panhandle Partnership for Health and Human Services (PPHHS) is the large not-for-profit organization which promotes collective impact through planning and partnership. The inclusive membership based organization has conducted extensive assessment and planning processes, some of which are listed in the Appendix.

The collective listservs for these groups and their staff reach over 2,000 persons in the region. This was one of the primary methods of advertisement and communication throughout the process. Articles in newspapers, meetings with key partner groups, and PPHD's annual report, with a distribution of 26,000 copies, were used at strategic junctures.

Visioning
The email listservs and partner meetings were used to notify citizens about the MAPP Kick-Off meeting on February 4, 2011 in Bridgeport, Nebraska. Forty-one (41) persons from throughout the Panhandle attended. The group represented a cross-section of the region including: citizens at large, County Commissioners, public health, hospitals/healthcare, Area Office on Aging, behavior health and substance use, schools, youth serving organizations, domestic violence organizations, Area Health Education Center, University Extension, not-for-profit agencies, business/economic development, minority health, and emergency medical services.

Assessments

The four MAPP Assessments were conducted as follows:

Forces of Change

The Forces of Change Assessment identified forces such as legislation, technology and other impending changes that affect the context in which the community and its public health system operate. The Forces of Change Assessment was conducted at the February 2011 Kick-Off meeting. A Technology of Participation process was used to engage the forty-one participants in a consensus process.

Community Themes and Strengths

This section of the MAPP Assessment is intended to provide a deep understanding of the issues residents feel are important. This information was collected through survey, focus groups and a dialogue group as follows:

Surveys

A MAPP regional survey occurred between February and May 2011. The survey instrument was made available through the State of Nebraska. The survey was available online. Paper copies were also made available for those who did not have internet access. The survey was promoted and distributed through county fairs, partner meetings, community meetings and the listserv. It was also promoted in the PPHD Annual Report which is printed as an insert in the newspaper with a distribution of 26,000 households. A total of 564 citizens responded.

In 2010, Regional West Medical Center contracted with the Sigma Group of Lincoln, Nebraska, to conduct a Community Needs Assessment Telephone Survey. The 1,000 random calls sought information from residents of the Panhandle and surrounding area in three areas: health status assessment, unmet medical needs, and reasons for patient outmigration.

Regional West Medical Center has shared the extensive results of the survey with all of the area hospitals and the public health entities to frame regional planning and decisions.

Focus Groups
A total of fourteen focus groups were held in the region between February and June 2011. The focus groups were held in seven of the eleven counties. Each focus group was attended by eight to ten people, with the exception of one minority group that had 15 participants. The focus groups were facilitated by a combination of public health staff and local health system partners. Local partners were contracted to contact groups, establish locations and facilitate meetings. Minority focus groups were held in a culturally and linguistically competent manner. A common focus group format and standardized questions were used for all groups.

Table 1: Panhandle Assessment Focus Groups Locations

County	Adults	Youth	Minority
Box Butte	x		x Hispanic
Cheyenne	x		
Dawes	x		x Native American
Sheridan		x	x Native American
Kimball	x		
Morrill	x	x	
Scotts Bluff (Mitchell)	x		
Scotts Bluff	x(2)		x Minority Group x Native American

Community Dialogue
A regional *Summit for a Healthy Panhandle* was held in Gering, Nebraska, in July 2011. Over 150 persons, for all eleven counties, attended the full day event which included presentation of the Community Health Status Report and break out groups on Community Themes and Strengths.

Local Public Health System Assessment
The Local Public Health System Assessment, designed by National Public Health Performance Standards Program, measured the ten essential public health services. Forty persons attended the meeting which used a power point presentation of the questions, and a clicker voting method to complete the assessment.

Community Health Status Assessment
The core of the Community Health Status Assessment was completed with data compiled and released through Nebraska Department of Health and Human Services (NE DHHS). The data, culled from many sources, is compared to state-wide data. Trend data is provided as available. The data is provided in report format and was presented by representatives of NE DHHS at the *Summit for a Healthier Panhandle*.

This Community Health Status Assessment is enhanced with the County Health Rankings.

Related Assessments and Plans
Other recent regional assessments and planning processes have been undertaken through standardized processes and are also considered part of the Community Health Status Assessment. The actual assessments are available in the Appendix. These assessments, and their components, are as follows:

Table 2: Related Assessments and Plans

Assessment	Partner Entity	Data	Focus/Community Groups	Year Completed/ Updated
Substance Abuse Prevention (SPF SIG)	NE DHHS	Youth Behavior Risk Survey	11 County Focus Groups Key Informant Interviews Minority Focus Groups 4 community Meetings	2008 Data updated every 2 years
Child Well Being	Nebraska Children and Families Foundation	State Child Well Being Indicators	3 Community Workgroups	2010 Data updated annually
Home Visitation (Affordable Care Act)	NE DHHS	Child Safety Risk Factor Data (DHHS)	4 Community Meetings	2011 Updated annually
Regional Comprehensive Juvenile Services and Violence Prevention Plan	NE Crime Commission and the Juvenile Justice institute	County Juvenile Arrest Data Disproportionate Minority Contact Data	6 Regional Planning Meetings 4 Focus Groups 11 County Meetings	2011 DMC data 2012

Priority Selection Process

A regional meeting was held in November 2011 at the Harms Center in Scottsbluff with the MAPP stakeholders to review the assessment information gathered to date and to begin the prioritization process for the health priorities. The public health system priorities were chosen in 2012.

Health Priority Selection
Many important health and public health system issues surfaced during the MAPP assessments; however, it would be too difficult to address all of them. The following criteria were used to choose health priorities.

- **Magnitude or size of the problem**: Shows the number/percentage of the population involved;
- **Comparison with state results**: Compares local data with state and national data;
- **Historical trends**: Indicates whether the health issue is getting better, worse, or remaining the same;
- **Economic and social impact**: Reflects the impact on workforce productivity, health care costs, crime rates, education, and the health of the population;
- **Changeability**: Indicates whether the health issue can be influenced at the local level in the next three to five years through prevention strategies and whether there are evidence-based programs, policies, and practices available that can significantly impact the issue;
- **Capacity of the local public health system**: Reflects the skills, awareness, interest, and support by public health partners within the LHD region;
- **Readiness or political will**: Reflects the awareness, interest, and political support or lack of clear political opposition at both the state and community levels.

Rating Process
Nebraska DHHS provided a rating system for each of the above categories. Participants used data and consensus agreement to complete the rating process. Details of the process are available on request.

Influential Factors
As part of the review the following areas were seen to be beyond the scope of residents to change, but influential factors in health status. These areas also need to be considered when selecting priorities and activities. These areas are:

	NE	Panhandle	PPHD	SBCHD
SOCIOECONOMIC				
Persons living below poverty	**11.8%**	**15.6%**	15.2%	16.1%
Unemployment rates	**4.0%**	**3.8%**	3.4%	4.5%
GENERAL HEALTH STATUS				
General health status fair or poor	**12.3%**	**15.7%**	15.7%	15.6%
Poor physical health 10+ of last 30 days	**10.3%**	**13.7%**	13.2%	14.5%
Poor mental teath 10+ of last 30 days	**10.3%**	**13.0%**	12.0%	14.4%
ACCESS TO HEALTH CARE				
Health Care Coverage				
No health care coverage (18- 64)	**15.2%**	**19.0%**	18.9%	19.3%
No personal doctor	**14.8%**	**17.2%**	18.0%	16.0%
Couldn't see doctor due to cost	**10.6%**	**14.3%**	14.2%	14.5%
Health Care Utilization (# of persons served per health professional)				
Physicians	**411**	**1272**	1895	451
Dentists	**1520**	**2048**	2142	1924
Nurses	**80**	**99**	121	71
Psychiatrists	**12,095**	**43,895**	-	18,485

Visioning for Health and Safety in the Panhandle

On February 4, 2011, more than 40 people came together in February to answer the question: "How will we, over the next three to five years, continue to develop and enhance our panhandle community to improve the health and safety for all who live, work, learn and play here?"

The first step in answering that question was to create a practical vision, answering this question: "What you see is the vision of what we would like to see in place as a result of our actions?" In summary, the answers to the vision questions are:

- ***Access to Services:*** *cost and accessibility for medical, dental and medical services, health insurance, distance, number of providers, patient education*
- ***Safer Communities:*** *intentional and unintentional injury, abuse, emergency preparedness*
- ***Compassionate Integrative Care:*** *treating physical, mental and social aspects, more humanity and interpersonal contact in service provision, prevention*
- ***Healthier Eating Environments:*** *community gardens, healthy school lunches and fast food options, obesity prevention*
- ***Active Living Opportunities:*** *more options for physical activity, walking trails, obesity prevention, worksite wellness*

- ***Decreased Substance Abuse:*** *tobacco use,legal and illegal substance abuse, responsible alcohol use*
- ***Policy to Promote Healthy Environments:*** *assure funding, educate policy makers, environmental supports*
- ***Quality of Life for all Ages:*** *intergenerational contacts, strengthen families, culture of health*
- ***Educated and Informed Community:*** *graduation rates, mental health awareness, affortable college education*

A complete workproduct from the visioning session is available in the Appendix.

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Assessment Data

Forces of Change

At the next planning session, attendees were tasked with the challenge of answering "What trends, factors and events are or will be influencing the health and safety in our Panhandle community and/or the work of the public health system?" The group identified the following forces of change:

- ***Geographic Challenges***
- ***Workforce Recruitment and Retention***
- ***Healthy Initiatives at National and Local Level***
- ***Technology Changes and Challenges***
- ***Demographic Changes***
- ***Cultural Shifts***
- ***Economic Shifts***
- ***Healthcare Uncertainties***
- ***Panhandle Strengths***
- ***Intolerance***

The following were identified as ***opportunities***:

- Collaboration continues
- Healthy initiatives at national/local level are priorities
- Rural beliefs
- Strength of our people
- Fiber optic network
- Use our problems to write grants to solve the problems
- Innovation.

The following were identified as ***challenges***:

- (Decrease in) volunteerism
- Potential for program cuts in state budget
- Increased government involvement in health care
- Wanting to go back to "way things were" instead of dealing with it as it is
- Sustainability
- Economic shifts
- Appropriate use of technology

A complete workproduct from the Forces of Change process is available in the Appendix.

Community Health Status Assessment

Population Characteristics: Demographics

2010 Census

Nebraska		Panhandle Region		Panhandle HD		Scotts Bluff County	
number	%	number	%	number	%	number	%
1,826,341	100.0	87,789	100.0	50,819	100.0	36,970	100.0

Percentage Changes 2000 to 2010

Nebraska		Panhandle Region		Panhandle HD		Scotts Bluff County	
number +/-	% chg	Number +/-	% chg	number +/-	% chg	number +/-	% chg
115,078	6.7	-2,621	-2.9	-2,640	-4.9	19	0.1

Population Characteristics: Socioeconomic

Persons Below the Poverty Level, 2010 Census

Nebraska		Panhandle Region		Panhandle HD		Scotts Bluff County	
number	%	number	%	number	%	number	%
201,851	11.8	12,926	15.6	7,245	15.2	5,681	16.1

Percentage Changes 2000 to 2010

Nebraska		Panhandle Region		Panhandle HD		Scotts Bluff County	
number +/-	% chg	number +/-	% chg	number +/-	% chg	number +/-	% chg
40,582	25.2	1,017	8.2	577	8.7	440	8.4

Unemployment – May 2011, not seasonally adjusted*

Nebraska		Panhandle Region		Panhandle HD		Scotts Bluff County	
number	%	number	%	number	%	number	%
39,747	4.0	1,766	3.8	896	3.4	870	4.5

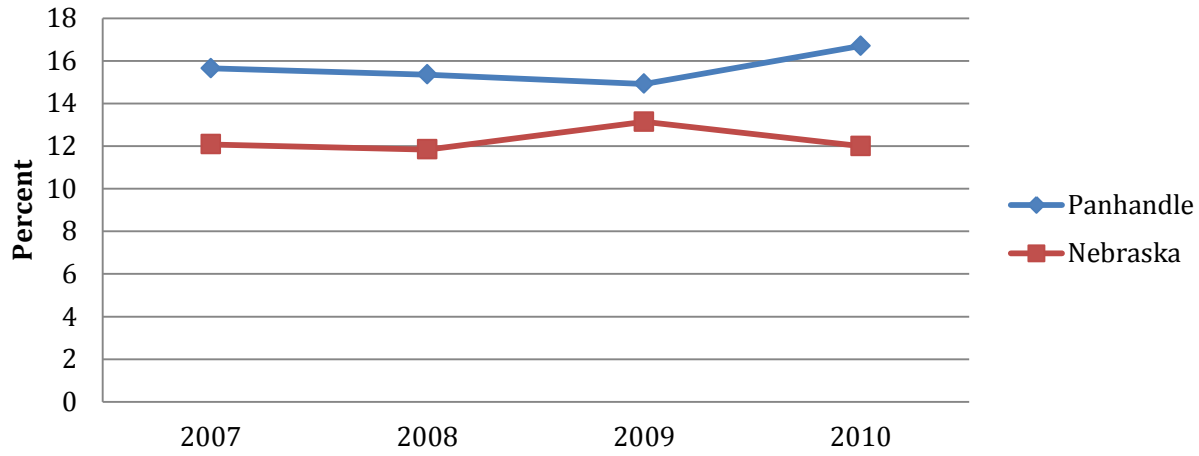
*Source: Nebraska Department of Labor

General Health Status: Self-reported Health Status

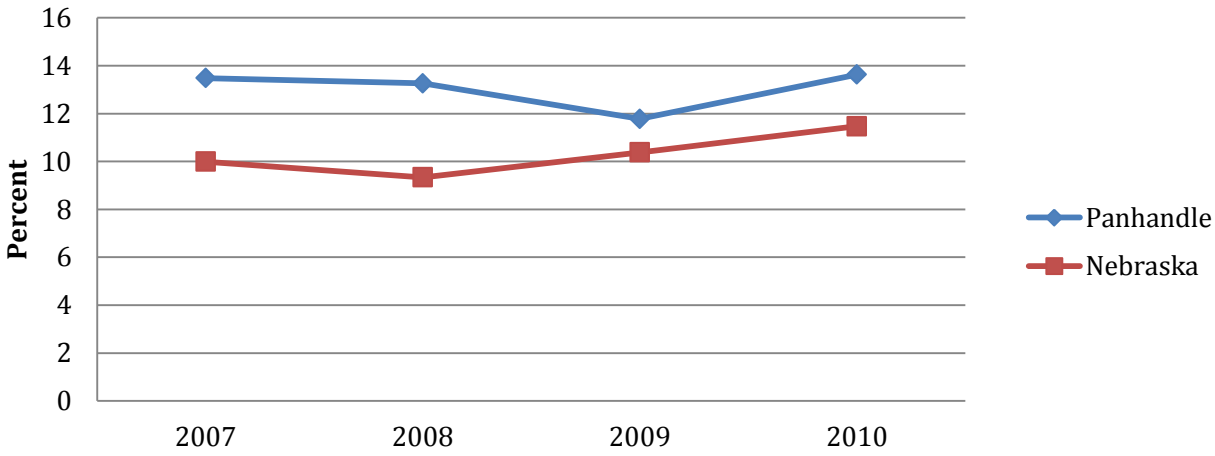
	Years Combined	Geographic Region			
		Nebraska	Panhandle	PanhandleHD	SBCounty
General health status fair or poor[1]	2007-2010	12.3% (11.8-12.8)	15.7% (14.6-16.8)	15.7% (14.3-17.3)	15.6% (14.0-17.3)
Poor physical health 10+ of past 30 days[2]	2007-2010	10.3% (9.9-10.8)	13.7% (12.6-14.9)	13.2% (11.8-14.7)	14.5% (12.8-16.5)
Poor mental health 10+ of past 30 days[3]	2007-2010	10.3% (9.7-10.9)	13.0% (11.8-14.4)	12.0% (10.6-13.7)	14.4% (12.4-16.7)

[1]Percent of adults, 18 and older, who reported that in general their health was fair or poor on a five point scale consisting of excellent, very good, good, fair, or poor
[2]Percent of adults, 18 and older, who reported that their physical health (including physical illness and injury), was not good on 10 or more of the 30 days preceding the survey
[3]Percent of adults, 18 and older, who reported that their mental health (including stress, depression and problems with emotions), was not good on 10 or more of the 30 days preceding the survey
Source: Behavioral Risk Factor Surveillance System (BRFSS)

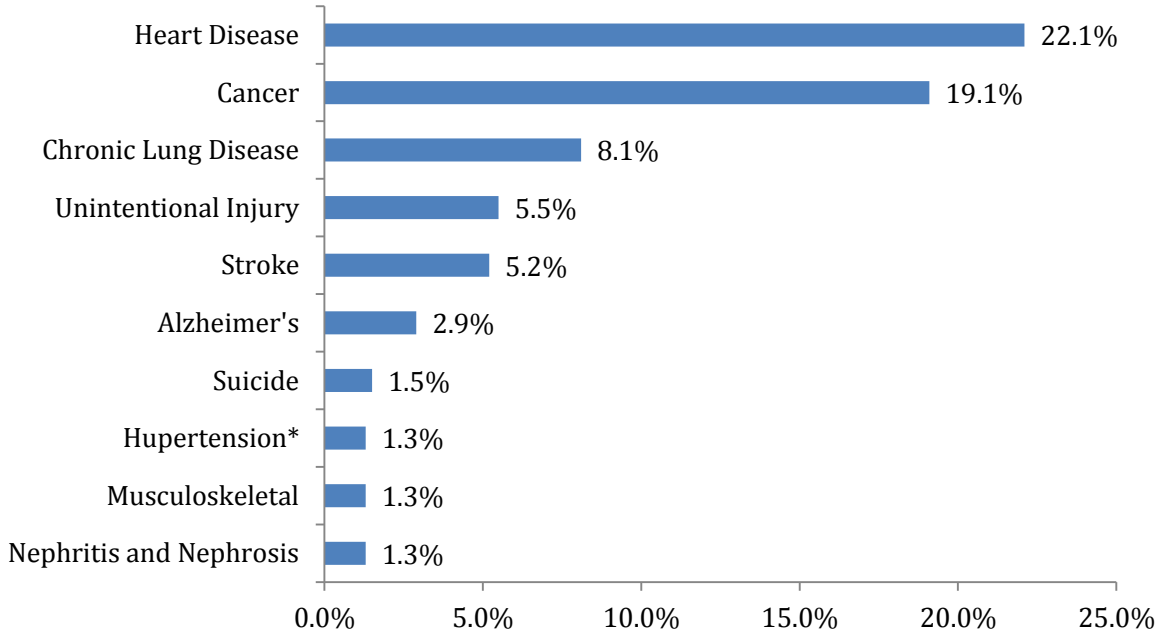
General Health Status: Physical Health Not Good 10+ Days in Past Month



General Health Status: Mental Health Not Good in 10+ Days in Past Month

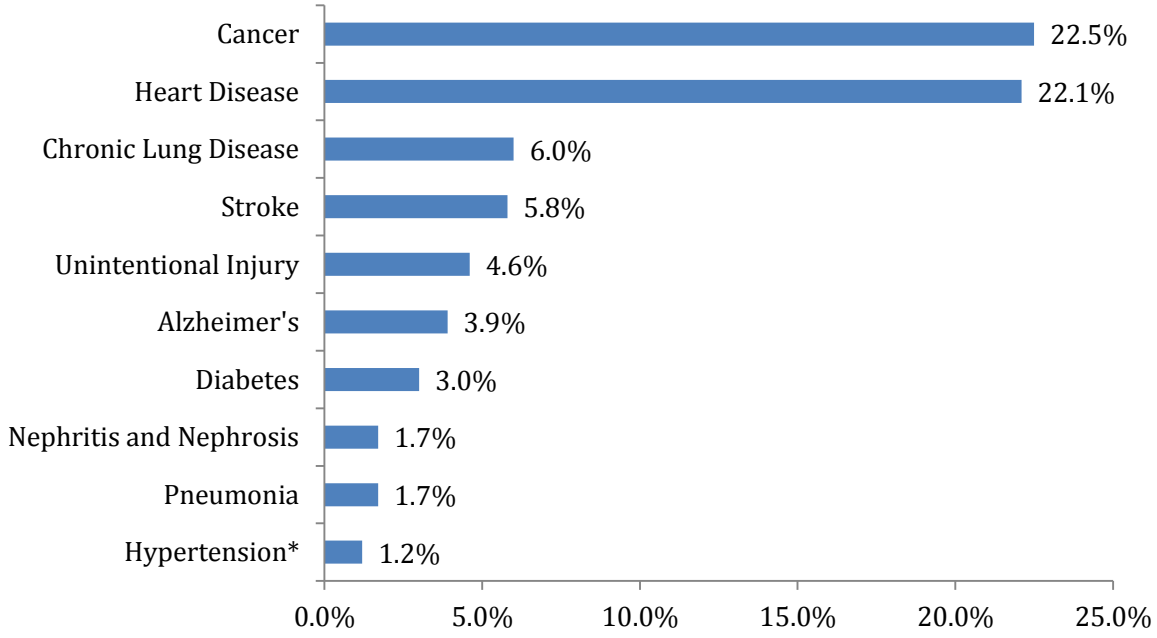


General Health Status: Ten Leading Causes of Death in the Panhandle, 2009



*Essential Hypertension and Hypertensive Renal Disease
Source: Nebraska Vital Records

General Health Status: Ten Leading Causes of Death in Nebraska, 2009



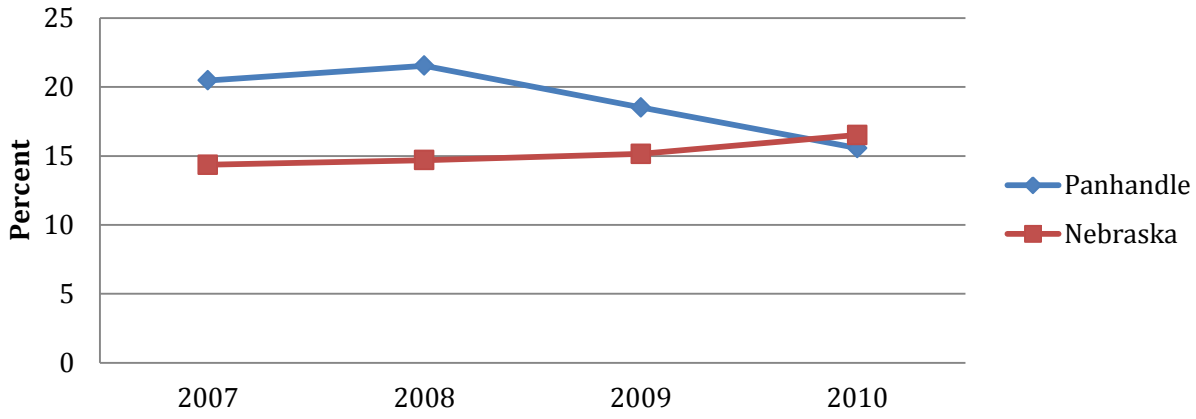
*Essential Hypertension and Hypertensive Renal Disease
Source: Nebraska Vital Records

Health Care Access and Utilization: Health Care Coverage

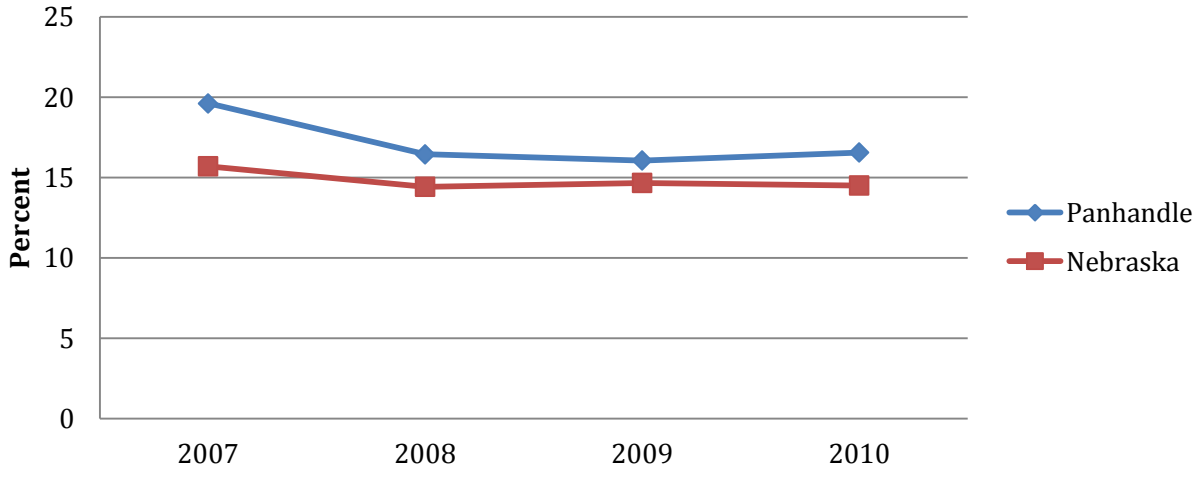
		Geographic Region			
	Years Combined	Nebraska	Panhandle	PanhandleHD	SBCounty
No health care coverage, 18-64 years old[1]	2007-2010	15.2% (14.3-16.1)	19.0% (17.3-20.9)	18.9% (16.6-21.4)	19.3% (16.5-22.3)
No personal doctor[2]	2007-2010	14.8 % (14.1-15.6)	17.2% (15.8-18.7)	18.0% (16.2-20.0)	16.0% (13.9-18.4)
Couldn't see a doctor due to cost in past year[3]	2007-2010	10.6% (10.0-11.2)	14.3% (13.1-15.7)	14.2% (12.6-16.0)	14.5% (12.5-16.7)
Had a check-up in past year[4]	2007-2010	59.9% (59.0-60.8)	55.7% (53.9-57.5)	56.7% (54.4-59.0)	54.3% (51.5-57.1)

[1]Percent of adults, 18-64 years old, who reported having no health care coverage
[2]Percent of adults, 18 and older, who reported that they do not have one or more person(s) that they think of as their personal doctor or health care provider
[3]Percent of adults, 18 and older, who reported that there was a time in the past 12 months when they needed to see a doctor but could not because of cost
[4]Percent of adults, 18 and older, who visited a doctor for a routine check-up in the past 12 months
Source: Behavioral Risk Factor Surveillance System (BRFSS)

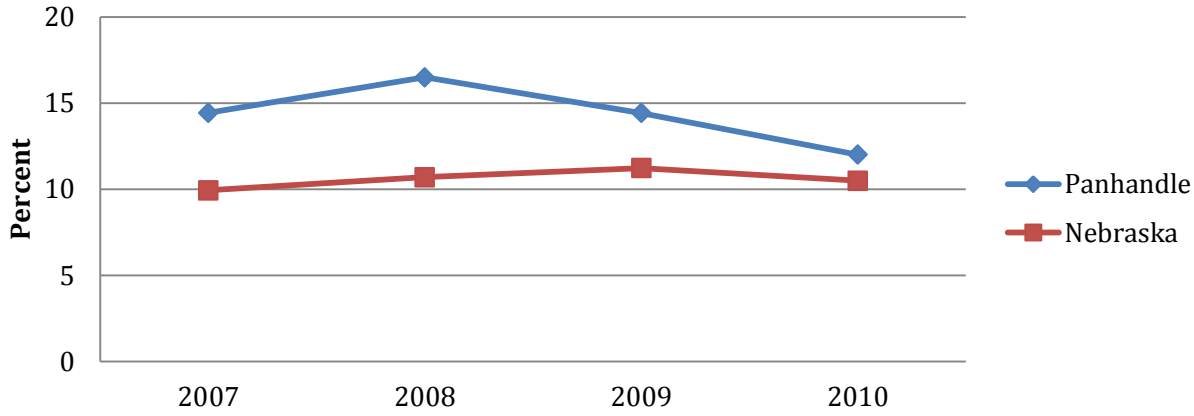
Health Care Access and Utilization: No Health Insurance, 18-64 Years Old



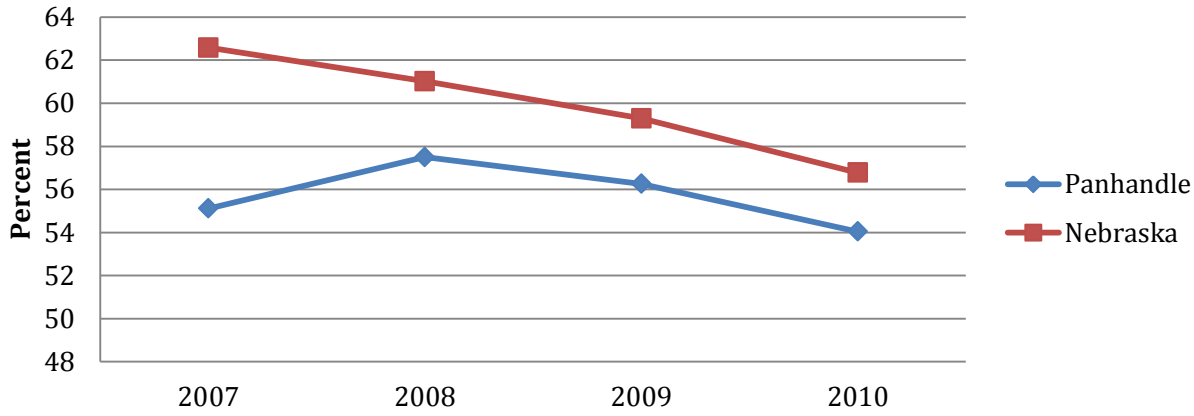
Health Care Access and Utilization: No Personal Doctor



Health Care Access and Utilization: Couldn't See Doctor Due to Cost in Past Year



Health Care Access and Utilization: Had Check-Up in Past Year



Health Care Access and Utilization: Availability of Providers

Number of Persons Served Per Health Care Professional		Geographic Region			
	Year	Nebraska	Panhandle	PanhandleHD	SBCounty
Physicians	2010	441	1,272	1.895	451
Dentists	2010	1,520	2,048	2,142	1,924
RNs	2010	80	99	121	71

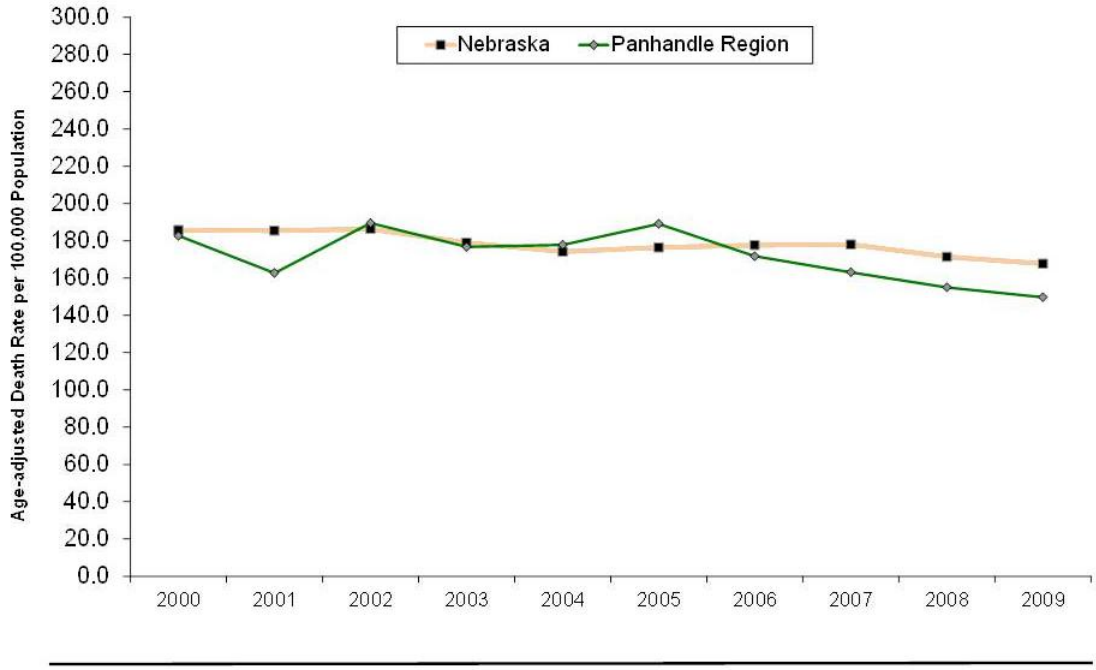
Source: UNMC Health Professions Tracking Service

Cancer: Mortality

Years	Geographic Region							
	Nebraska		Panhandle		Panhandle HD		Scotts Bluff County	
2005-2009	n	rate	n	rate	n	rate	n	rate
	16.969	174.0	978	165.6	585	168.7	393	161.4

Source: Nebraska Vital Records

Cancer: Mortality Trend (age-adjusted), Panhandle and Nebraska, 2000-2009



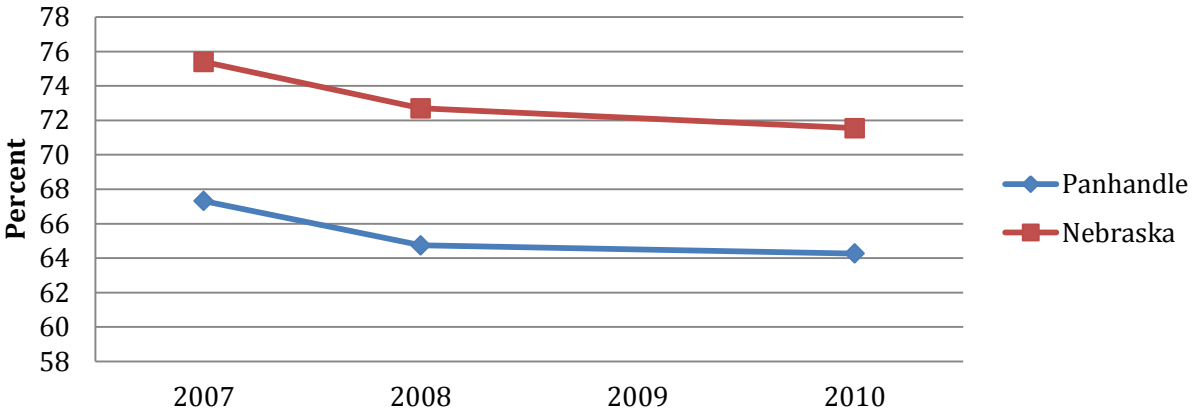
Source: Nebraska Vital Records

Cancer: Preventive Screenings for Cancer

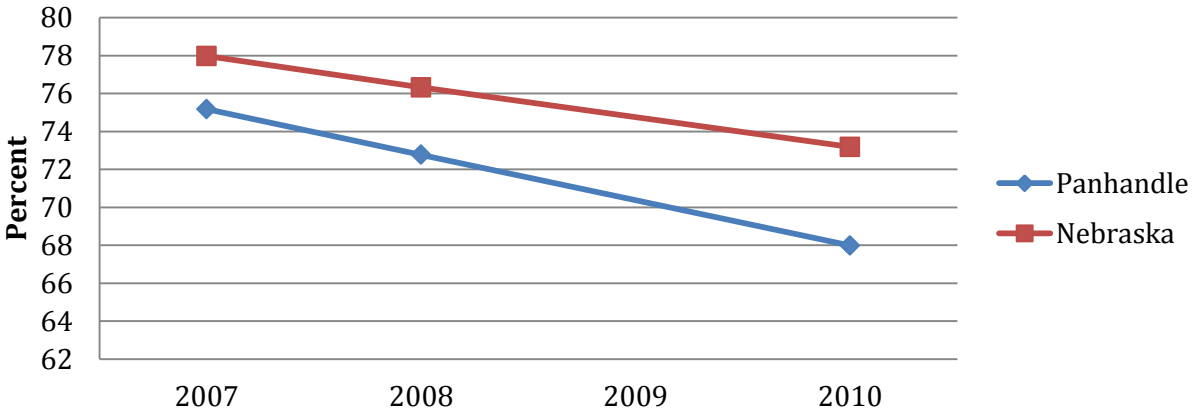
	Years Combined	Geographic Region			
		Nebraska	Panhandle	PanhandleHD	SBCounty
Mammogram in past two years, Women 40+[1]	2007-2008, 2010	72.8% (71.7-73.9)	65.1% (62.6-67.5)	65.2% (61.8-68.4)	65.0% (61.3-68.5)
Pap test in past three years, Women 18+[2]	2007-2008, 2010	75.4% (74.2-76.5)	71.3% (69.0-73.6)	72.8% (69.8-75.6)	69.5% (65.7-73.0)
Ever had colon cancer screenings, all 50+[3]	2007-2010	59.3% (58.3-60.2)	49.8% (47.9-51.8)	50.2% (47.5-52.9)	49.4% (46.5-52.3)
PSA test in past two years, Men 40+[4]	2008, 2010	52.7% (51.1-54.4)	53.3% (49.9-56.6)	57.4% (52.7-61.9)	47.6% (42.8-52.4)

[1]Percent of women, 40 and older, who reported having a mammogram in the past two years
[2]Percent of women, 18 and older, who reported having a pap test in the past three years
[3]Percent of adults, 50 and older, who reported that they have ever had a sigmoidoscopy or colonoscopy
[4]Percent of men, 40 and older, who reported having a PSA exam during the past two years
Source: Behavioral Risk Factor Surveillance System (BRFSS)

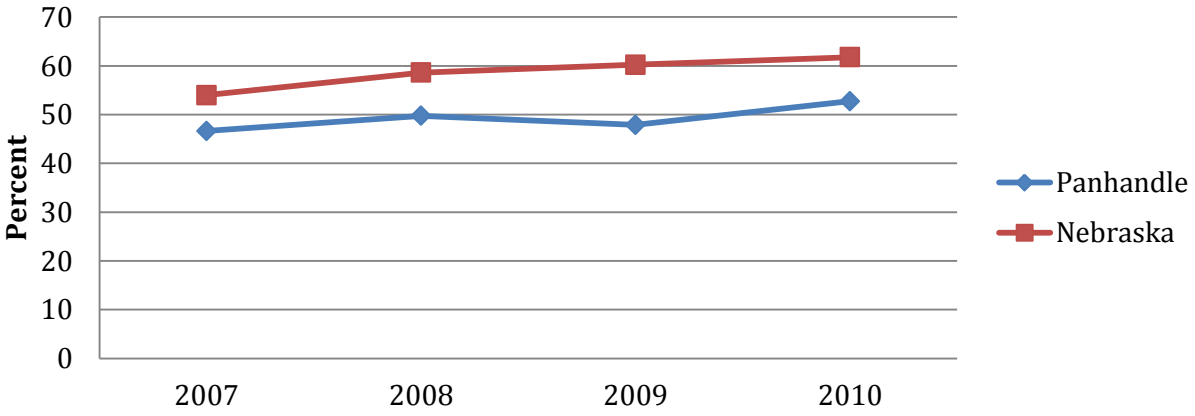
Cancer: Had Mammogram in Past 2 Years, Among Women 40+



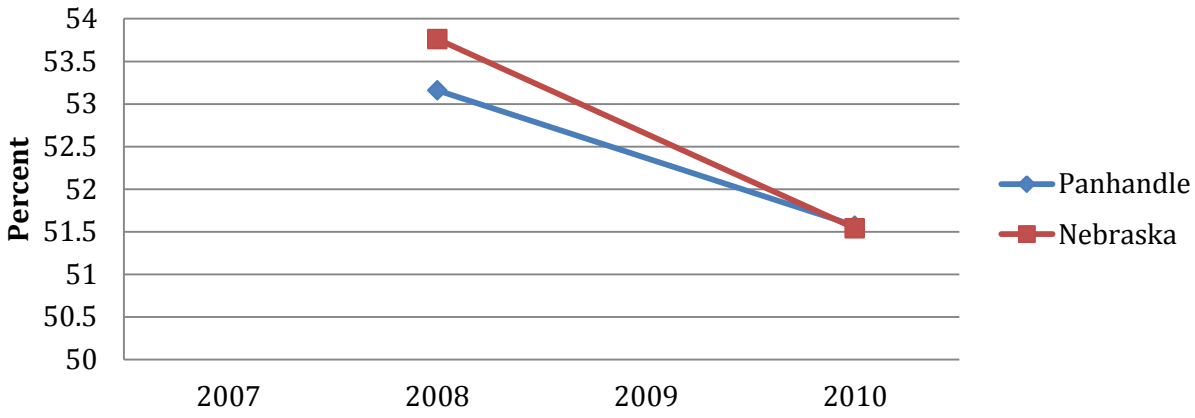
Cancer: Had Pap Test in Past Three Years, Among Women 18+



Cancer: Ever Had Sigmoidoscopy or Colonoscopy, Among 50+



Cancer: Had PSA Test in Past 2 Years, Among Men 40+



Heart Disease and Stroke: Heart Disease Mortality

Years	Geographic Region							
	Nebraska		Panhandle		Panhandle HD		Scotts Bluff County	
2005-2009	n	rate	n	rate	n	rate	n	rate
	17,364	165.6	1,165	177.9	636	164.6	529	197.5

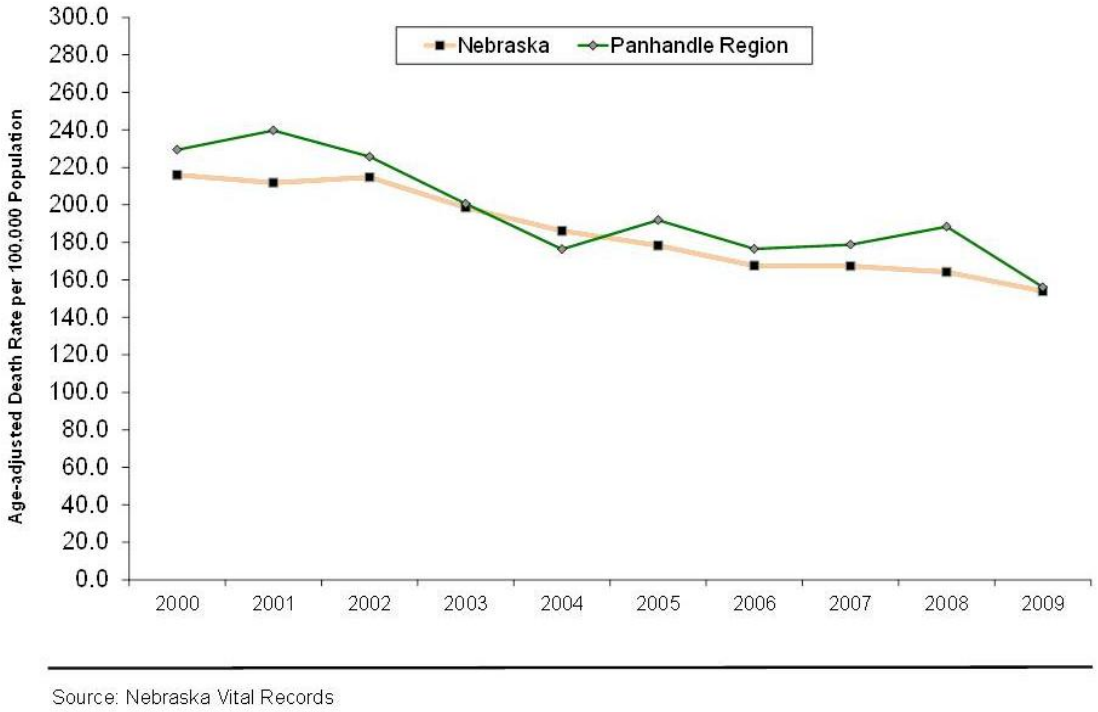
Source: Nebraska Vital Records

Heart Disease and Stroke: Stroke Mortality

Years	Geographic Region							
	Nebraska		Panhandle		Panhandle HD		Scotts Bluff County	
2005-2009	n	rate	n	rate	n	rate	n	rate
	4,509	42.9	267	40.0	148	37.0	119	44.2

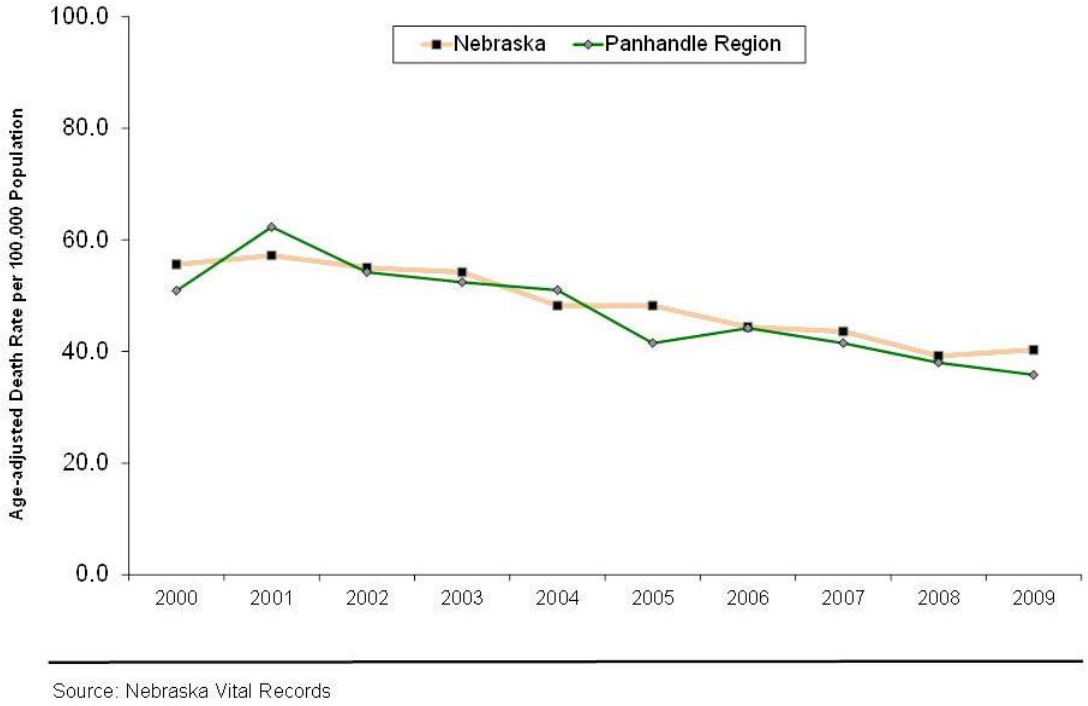
Source: Nebraska Vital Records

Heart Disease and Stroke: Heart Disease Mortality Trend (age-adjusted), Panhandle and Nebraska, 200-2009



Source: Nebraska Vital Records

Heart Disease and Stroke: Stroke Mortality Trend (age-adjusted), Panhandle and Nebraska, 2000-2009



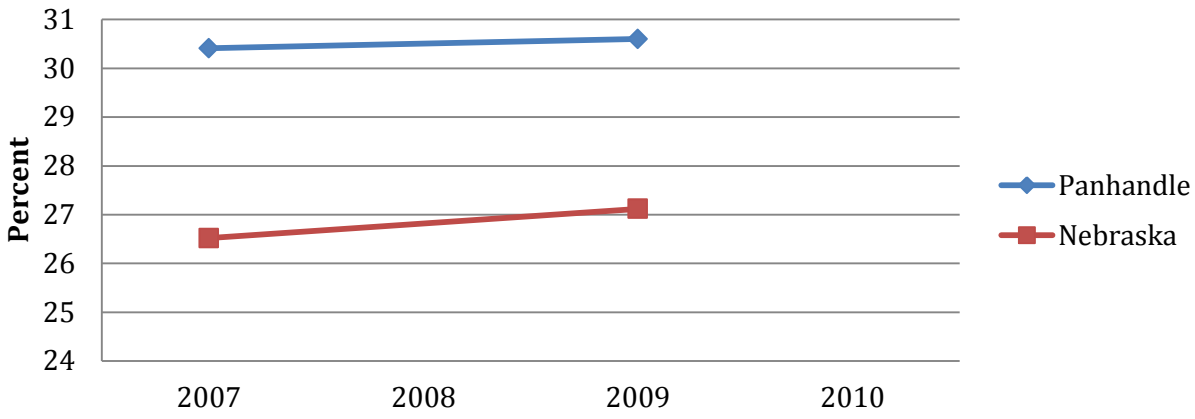
Source: Nebraska Vital Records

Heart Disease and Stroke: Risk Factors for Heart Disease and Stroke

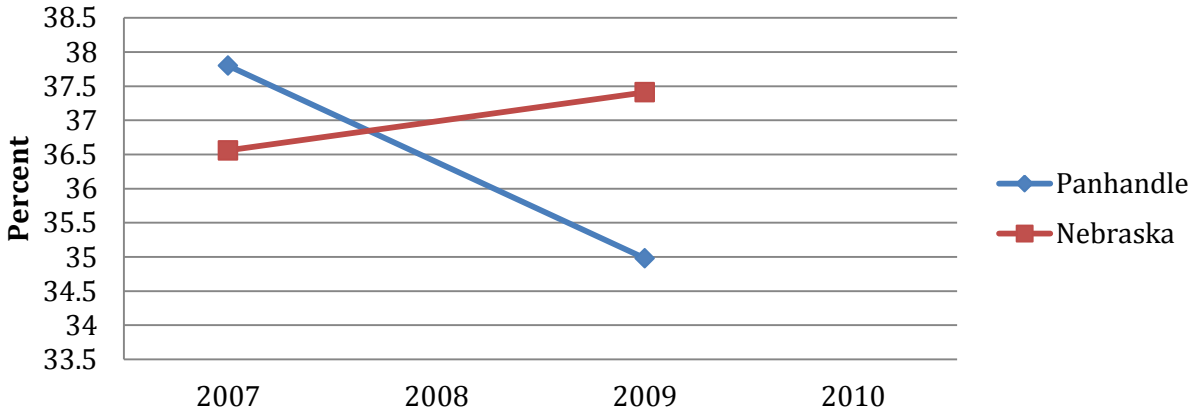
		Geographic Region			
	Years Combined	Nebraska	Panhandle	PanhandleHD	SBCounty
Ever told you have high blood pressure[1]	2007, 2009	26.8% (25.8-27.8)	30.5% (28.4-32.7)	31.2% (28.4-34.2)	29.5% (26.4-32.9)
Ever told you have high blood cholesterol[2]	2007, 2009	37.0% (35.8-38.2)	36.4% (33.9-38.9)	37.4% (34.1-40.7)	34.9% (31.2-38.9)
Had blood cholesterol checked in past 5 years[3]	2007, 2009	73.8% (72.5-75.1)	71.7% (68.9-74.4)	72.6% (69.0-75.9)	70.6% (66.0-74.8)

[1]Percent of adults, 18 and older, who reported that they have ever been told by a doctor, nurse, or other health professional that they have high blood pressures
[2]Percent of adults, 18 and older, who reported that they have ever been told by a doctor, nurse, or other health professional that their blood cholesterol is high
[3]Percent of adults, 18 and older, who reported that they have had their blood cholesterol checked during the five years preceding the survey
Source: Behavioral Risk Factor Surveillance System (BRFSS)

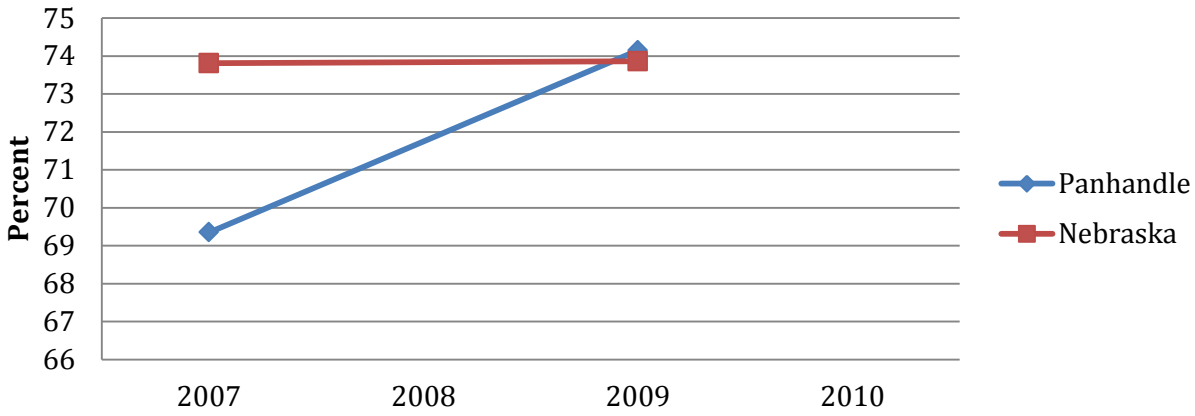
Heart Disease and Stroke: Ever Told BP High



Heart Disease and Stroke: Ever Told Cholesterol High



Heart Disease and Stroke: Cholesterol Checked in Past 5 Years

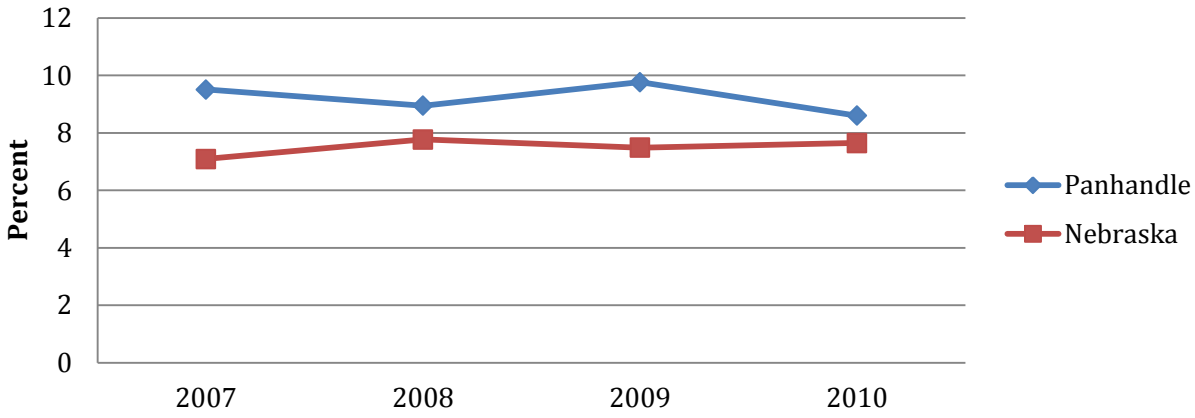


Diabetes: Diabetes Prevalence

	Years Combined	Geographic Region			
		Nebraska	Panhandle	Panhandle HD	SB County
Diagnosed Diabetes[1]	2005-2009	7.5% (7.2-7.9)	9.2% (8.4-10.1)	8.2% (7.2-9.2)	10.7% (9.4-12.1)

[1]Percent of adults, 18 and older, who reported that they have ever been told by a doctor that they have diabetes (excluding gestational diabetes and pre-diabetes)
Source: Behavioral Risk Factors Surveillance System (BRFSS)

Diabetes: Ever Told Have Diabetes



Immunization and Infectious Disease: Flu Vaccine

		Geographic Region			
	Years Combined	Nebraska	Panhandle	PanhandleHD	SB County
Got flu shot in past year, aged 65 and older	2005-2009	74.4% (73.4-75.3)	67.6% (65.3-69.9)	65.9% (62.5-69.1)	70.1% (66.8-73.1)

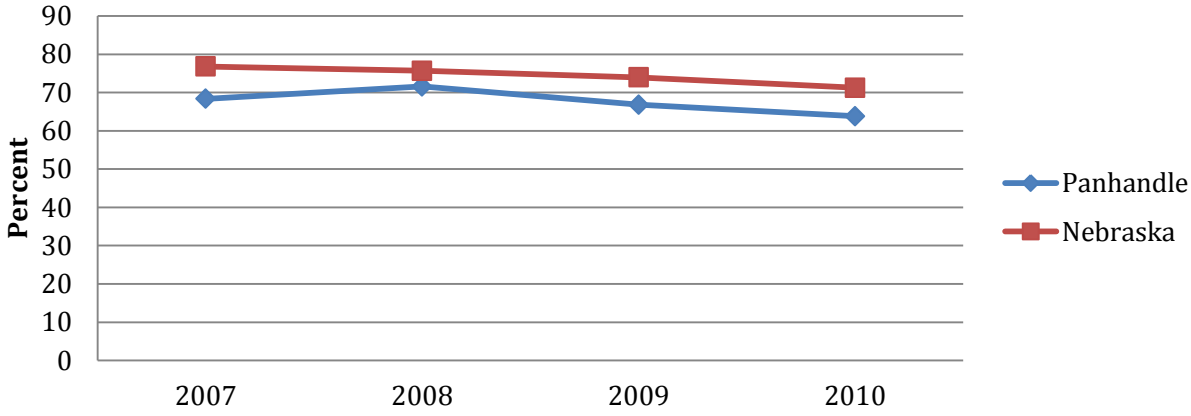
[1]Percent of adults, 65 and older, who reported that they received a flu shot or a flu vaccine that was sprayed in their nose during the 12 months preceding the survey
Source: Behavioral Risk Factors Surveillance System (BRFSS)

Immunization and Infectious Disease: Hepatitis A & B

Incidence rate per 100,000 population		Geographic Region			
	Years Combined	Nebraska	Panhandle	PanhandleHD	SB County
Hep A & B	2005-2009	16.9	5.8	3.2	9.3

Source: Division of Public Health, NDHHS

Immunization and Infectious Disease: Got Flu Shot in Past Year, Among 65+

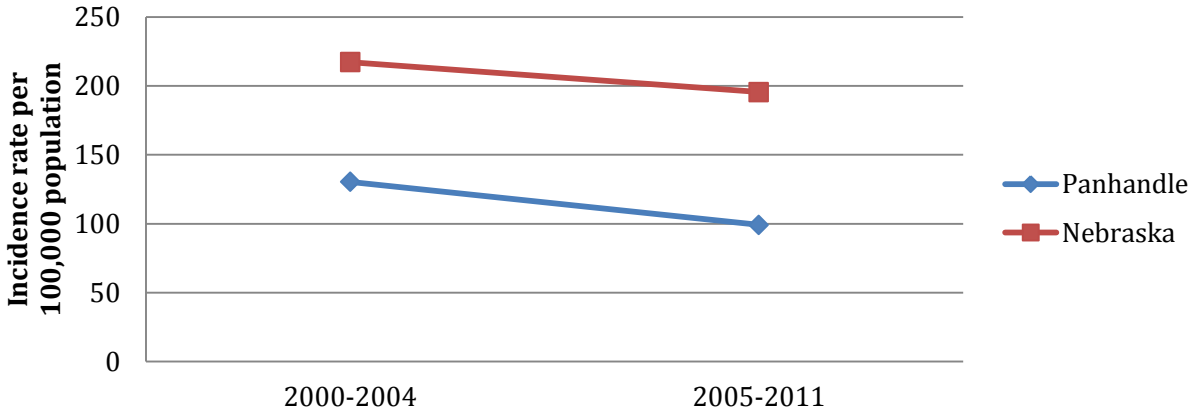


Immunization and Infectious Disease: Sexually Transmitted Infections (STIs)

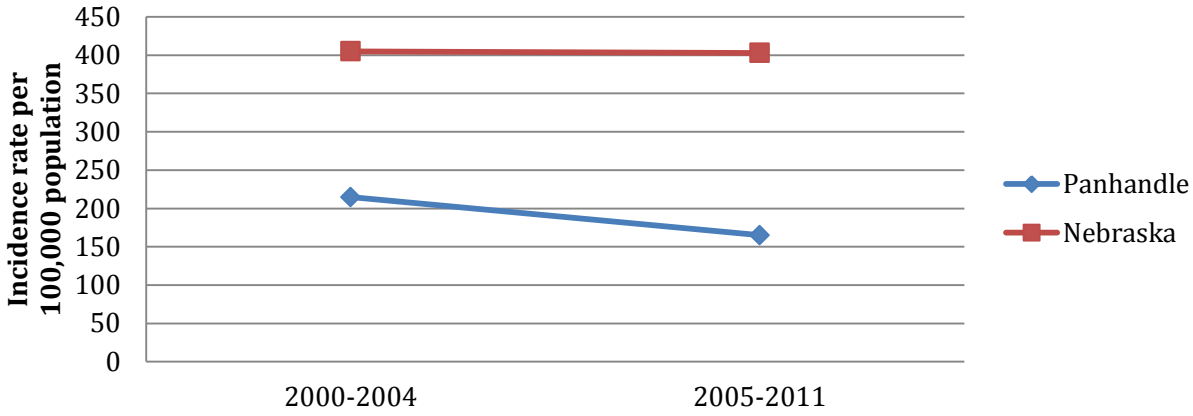
Incidence rate per 100,000 population		Geographic Region			
	Year	Nebraska	Panhandle	PanhandleHD	SB County
All STIs, <18 years old	2005-2009	195.6	99.2	77.6	127.7
All STIs, 18+	2005-2009	402.9	165.1	120.8	223.4

Source: Division of Public Health, NDHHS

Immunization and Infectious Disease: Sexually Transmitted Infections, <18



Immunization and Infectious Disease: Sexually Transmitted Infections, 18+



Injury and Violence Prevention: Prevalence of Seat Belt Use

		Geographic Region			
	Years Combined	Nebraska	Panhandle	PanhandleHD	SB County
Always/nearly always wear seat belt[1]	2008, 2010	88.2% (87.5-88.9)	82.1% (80.0-84.0)	81.9% (79.1-84.4)	82.4% (79.2-85.2)

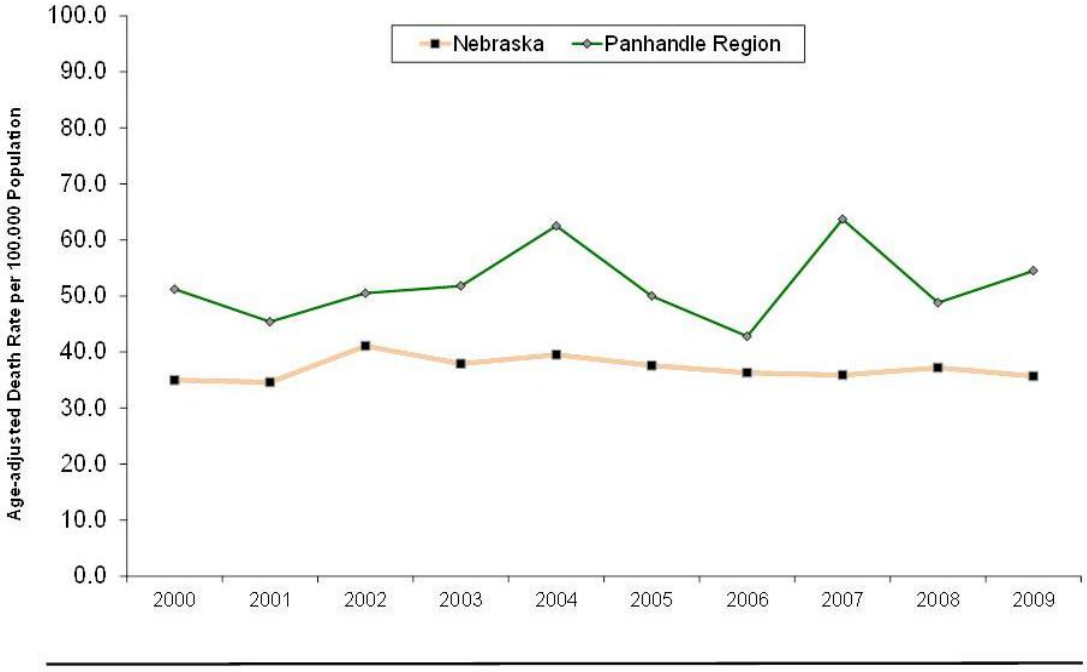
[1]Percent of adults, 18 and older, who reported that they always or nearly always wear a seat belt when driving or riding in a car
Source: Behavioral Risk Factors Surveillance System (BRFSS)

Injury and Violence Prevention: Unintentional Injury Death Rate

	Geographic Region							
Years	Nebraska		Panhandle		Panhandle HD		Scotts Bluff County	
	n	rate	n	rate	n	rate	n	rate
2005-2009	3,460	36.5	249	51.8	150	53.7	99	49.1

Source: Nebraska Vital Records

Injury and Violence Prevention: Unintentional Injury Mortality Trend (age-adjusted), Panhandle and Nebraska, 200-2009



Source: Nebraska Vital Records

Maternal Child Health: Infant Mortality Rate

Infant Deaths (under age 1) per 1,000 Live Births	Geographic Region							
Years	Nebraska		Panhandle		Panhandle HD		Scotts Bluff County	
	n	rate	n	rate	n	rate	n	rate
2005-2009	769	5.8	36	6.2	15	5.0	21	7.6

Source: Nebraska Vital Records

Maternal Child Health: Teen Births

Teen Births as a Percentage of All Births	Geographic Region							
Years	Nebraska		Panhandle		Panhandle HD		Scotts Bluff County	
	n	%	n	%	n	%	n	%
2005-2009	11,168	8.4	692	12.0	308	10.2	384	13.9

Source: Nebraska Vital Records

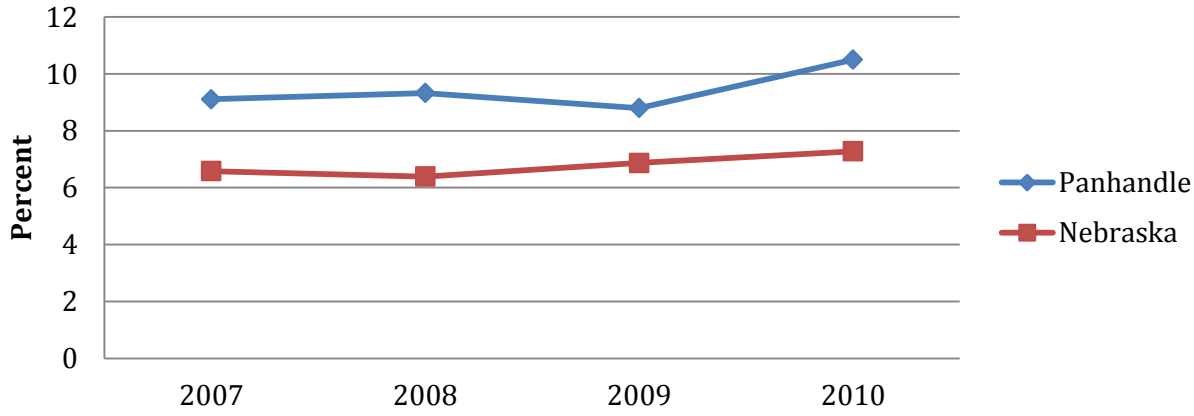
Mental Health: Prevalence of Mental Health Treatment, Social/Emotional Support, and Life Satisfaction

	Years Combined	Geographic Region			
		Nebraska	Panhandle	Pan. HD	SB County
Rarely or never get needed social and emotional support[1]	2008- 2010	6.8% (6.4-7.2)	9.4% (8.3-10.7)	9.8% (8.4-11.4)	8.9% (7.2-11.0)
Dissatisfied with life[2]	2007-2010	4.0% (3.6-4.3)	3.9% (3.2-4.6)	4.0% (3.1-5.0)	3.7% (2.8-4.8)
Receiving mental health treatment[3]	2007, 2009	10.0% (8.9-11.2)	10.0% (8.1-12.4)	12.1% (9.2-15.7)	7.5% (5.4-10.4)

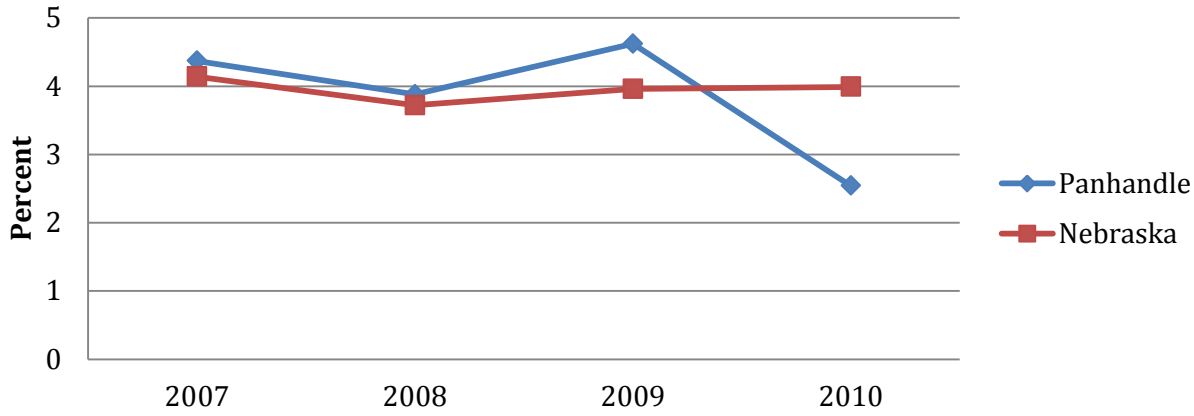
[1]Percent of adults, 18 and older, who reported that they rarely or never get the social and emotional support they need, based on a five-point scale consisting of: always, usually, sometimes, rarely, and never
[2]Percent of adults, 18 and older, who reported that they are dissatisfied with their life, based on a four-point scale consisting of: very satisfied, satisfied, dissatisfied, and very dissatisfied
[3]Percent of adults, 18 and older, who reported that they are taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem

Source: Behavioral Risk Factors Surveillance System (BRFSS)

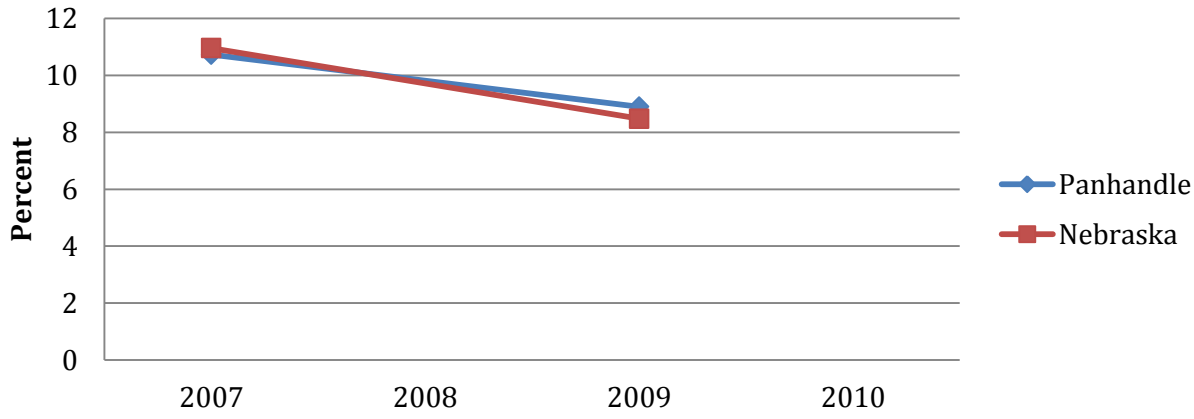
Mental Health: Rarely/Never Get Emotional Support They Need



Mental Health: Dissatisfied with Life



Mental Health: Receiving Mental Health Treatment



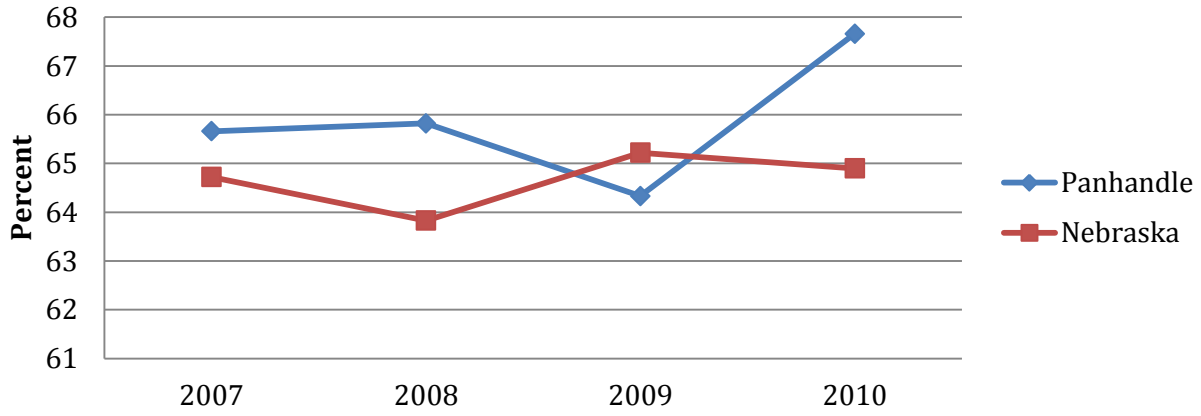
Nutrition and Overweight: Prevalence of Overweight, Obesity, and Fruit and Vegetable Consumption

	Years Combined	Geographic Region			
		Nebraska	Panhandle	Pan. HD	SB County
Overweight (BMI 25+)[1]	2007-2010	64.7% (63.8-65.6)	65.9% (64.1-67.6)	65.0% (62.6-67.2)	67.1% (64.3-69.9)
Obesity (BMI 30+)[2]	2007-2010	27.7% (27.0-28.5)	29.7% (28.1-31.3)	27.3% (25.3-29.4)	33.0% (30.4-35.7)
Fruits and veggies 5+ times per day[3]	2007, 2009	22.6% (21.6-23.7)	23.1% (20.8-25.5)	23.2% (20.5-26.1)	22.9% (19.3-27.1)

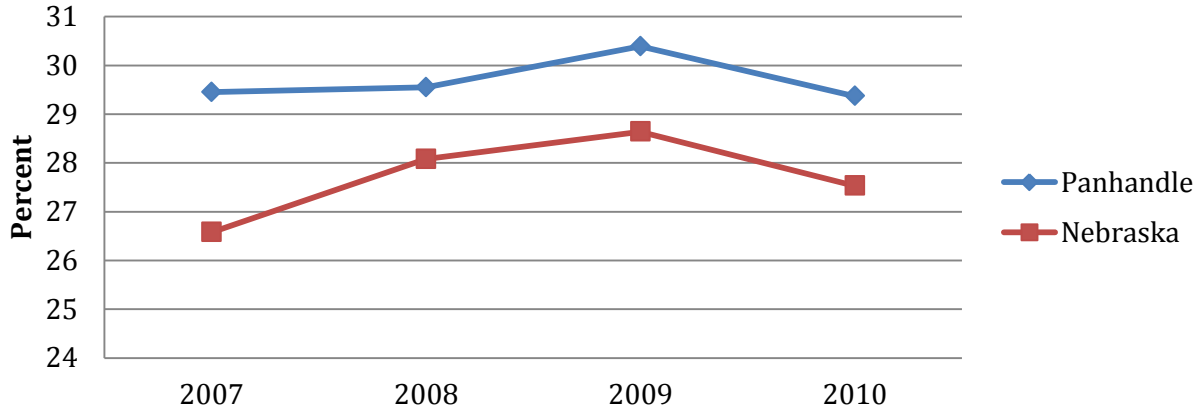
[1]Percent of adults, 18 and older, with a body mass index (BMI) of 25.0 or higher
[2]Percent of adults, 18 and older, with a body mass index (BMI) of 30.0 or higher
[3]Percent of adults, 18 and older, who reported that they consume fruits and vegetables five or more times per day

Source: Behavioral Risk Factors Surveillance System (BRFSS)

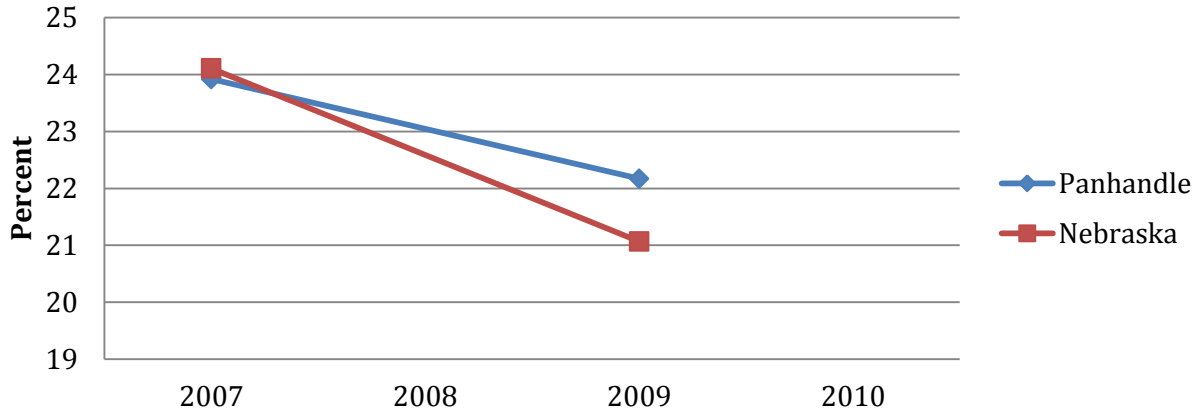
Nutrition and Overweight: Overweight (BMI 25+)



Nutrition and Overweight: Obese (BMI 30+)



Nutrition and Overweight: 5+ Fruits and Veggies



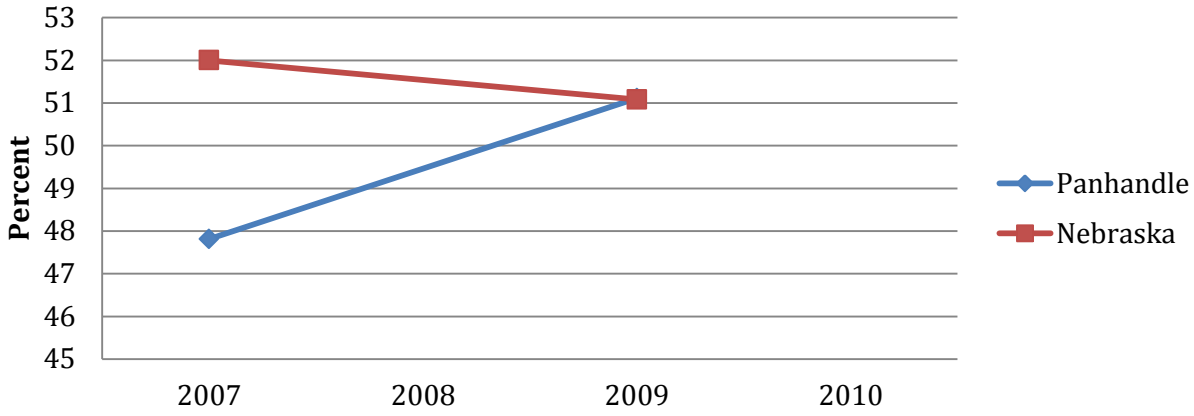
Physical Activity and Fitness: Participation in the Recommended Amount of Physical Activity

	Years Combined	Geographic Region			
		Nebraska	Panhandle	Pan. HD	SB County
Recommended amount of physical activity[1]	2007-2010	51.5% (50.2-52.9)	49.4% (46.7-52.2)	49.3% (45.8-52.8)	49.6% (45.2-54.1)

[1]Percent of adults, 18 and older, who reported that they engaged in 30 or more minutes of moderate physical activity on five or more days per week or vigorous physical activity for 20 or more minuets three or more times per week

Source: Behavioral Risk Factors Surveillance System (BRFSS)

Physical Activity and Fitness: Recommended Physical Activity (Mod and Vig)



Oral Health: Water Fluoridation

Percent of population receiving optimally fluoridated water		Geographic Region			
	Year	Nebraska	Panhandle	PanhandleHD	SB County
Coverage	2007	68.2%	36.2%	39.0%	32.5%

Source: Division of Public Health, NDHHS

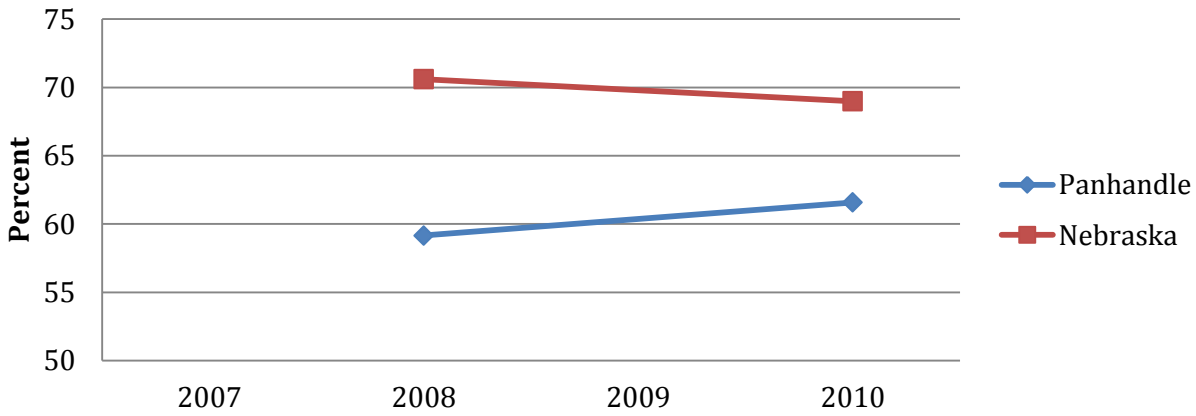
Oral Health: Dental Visits

		Geographic Region			
	Years Combined	Nebraska	Panhandle	Pan. HD	SB County
Visited a dentist or dental clinic in past year[1]	2008, 2010	69.8% (68.7-70.9)	60.4% (58.0-62.7)	61.2% (58.1-64.3)	59.2% (55.6-62.7)

[1]Percent of adults, 18 and older, who visited a dentist or dental clinic during the 12 months preceding the survey

Source: Behavioral Risk Factors Surveillance System (BRFSS)

Oral Health: Visited Dentist in Past Year



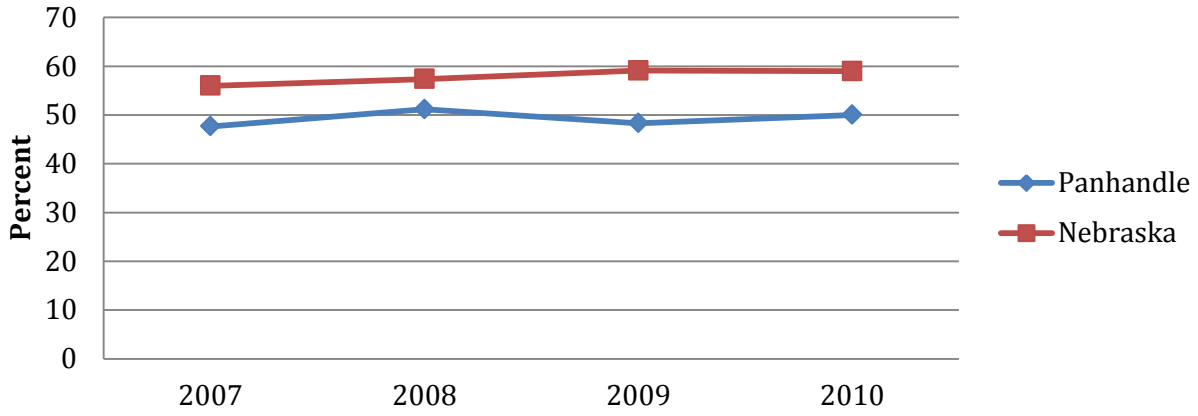
Alcohol Use: Prevalence of Alcohol Use and Impaired Driving

	Years Combined	Geographic Region			
		Nebraska	Panhandle	Pan. HD	SB County
Past month alcohol use [1]	2007-2010	57.9% (57.0-58.7)	49.3% (47.5-51.1)	52.7% (50.3-55.0)	44.6% (41.8-47.4)
Past month binge drinking[2]	2007-2010	18.6% (17.8-19.4)	14.7% (13.4-16.2)	17.6% (15.7-19.7)	10.8% (8.9-13.0)
Past Month impaired driving[3]	2008, 2010	5.8% (5.0-6.7)	5.6% (3.9-8.1)	5.2% (3.6-7.6)	6.3% (3.1-12.5)

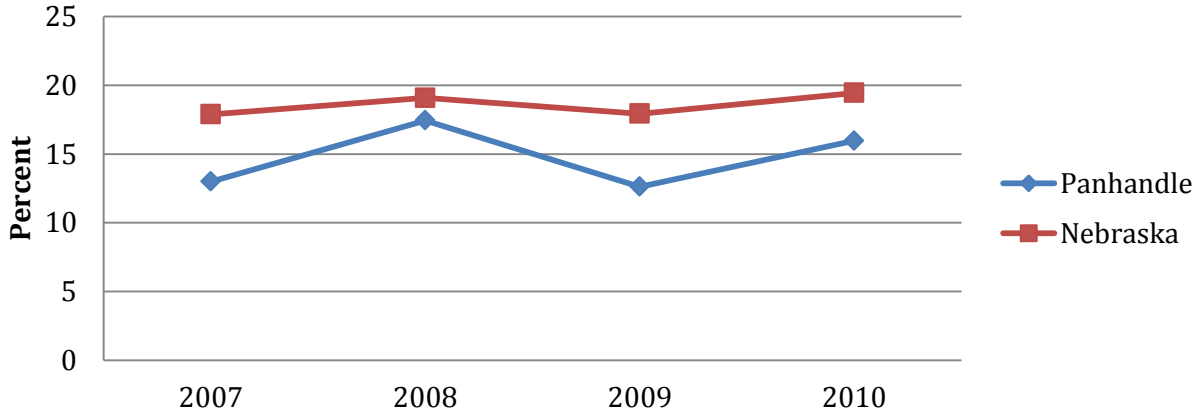
[1]Percent of adults, 18 and older, who reported drinking alcohol during the 30 days preceding the survey
[2]Percent of adults, 18 and older, who reported drinking five or more drinks for men/four or more drinks for women at least one occasion during the 30 days preceding the survey
[3]Percent of adults, 18 and older, who reported driving after having perhaps too much to drink

Source: Behavioral Risk Factors Surveillance System (BRFSS)

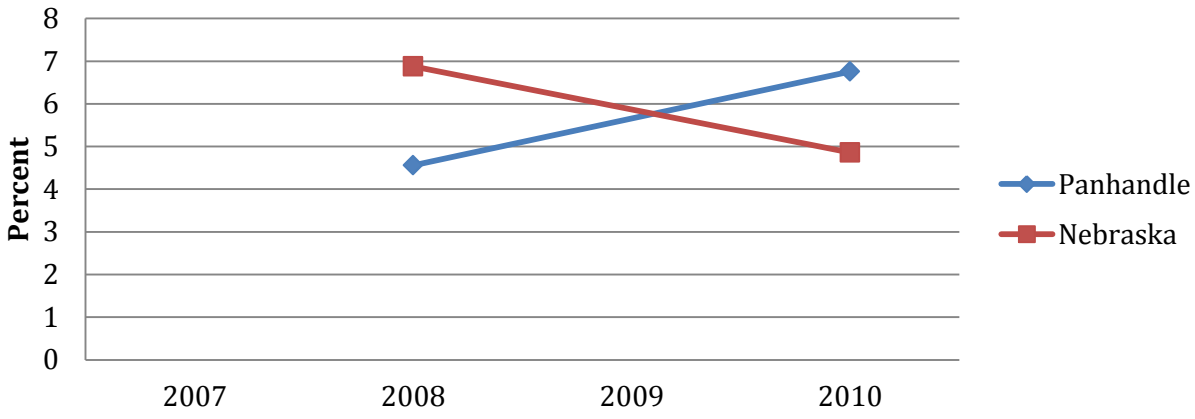
Alcohol Use: Alcohol in Past Month



Alcohol Use: Binge Drank in Past Month



Alcohol Use: Impaired Driving in Past Month



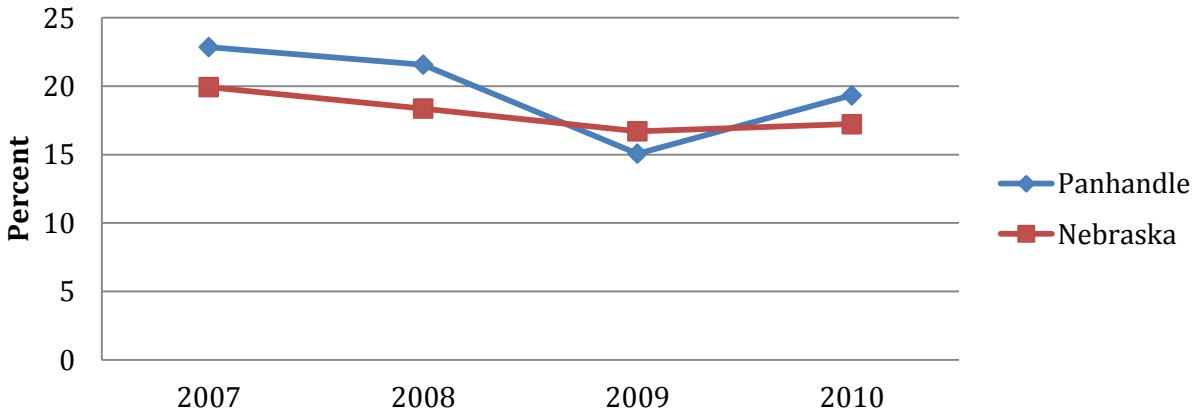
Tobacco Use: Prevalence of Cigarette Smoking and Quit Attempts

	Years Combined	Geographic Region			
		Nebraska	Panhandle	Pan. HD	SB County
Current cigarette smoking [1]	2007-2010	18.1% (17.3-18.8)	19.7% (18.3-21.2)	19.7% (17.9-21.6)	19.8% (17.5-22.3)
Attempted to quit in past year, among smokers[2]	2007-2010	54.1% (51.8-56.4)	50.2% (46.0-54.4)	50.2% (44.8-55.6)	50.2% (43.4-57.0)

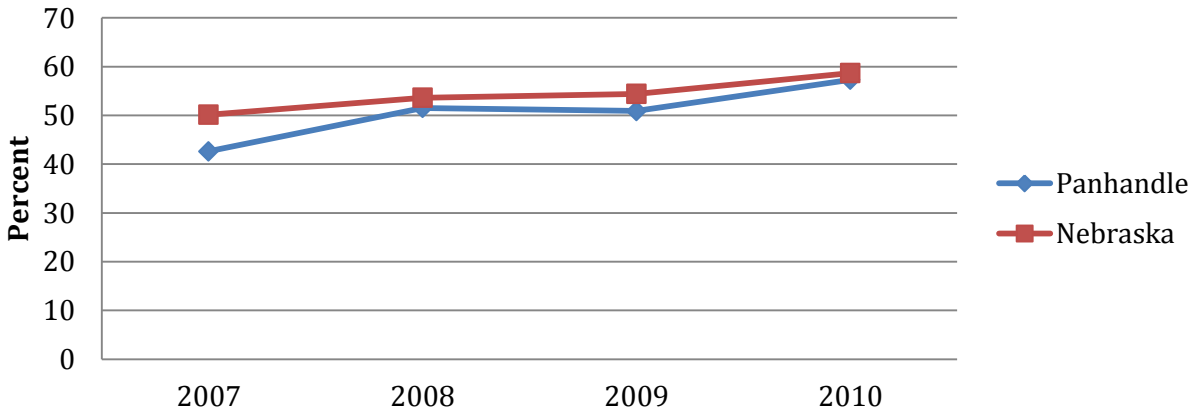
[1]Percent of adults, 18 and older, who reported that they currently smoke cigarettes
[2]Percent of adults, 18 and older, who reported that they stopped smoking for one day or longer because they were trying to quit smoking, during the 12 months preceding the survey

Source: Behavioral Risk Factors Surveillance System (BRFSS)

Tobacco Use: Current Smoking



Tobacco Use: Quit Attempt in Past Year



Local Public Health System Assessment

In May 2011, PPHD and SBCHD completed an assessment of the local public health system. In preparation, the core committee identified individuals to serve as facilitators and recorders for the assessment process. The committee also recruited participants from all parts of the local public health system, not just the local health departments. Based on state recommendations, the following list of potential stakeholders were invited to the essential service discussions:

Hospitals
Private physicians
Health departments
Insurance agents
Immunization providers
Specialty clinics
Interpreters
Police and fire departments
Mental health providers
Community action agencies
Community colleges (nursing departments)
Schools (K-12)
School and Parish nurses
Environmental health
USDA social services
EPA/water
Housing, emergency managers
Emergency response team members
Red Cross
Media
Seniors
Fitness centers (including YMCAs)
Utility providers
University of Nebraska Cooperative Extension Services
Organizations working with Minorities
Non-profit organizations
Civic groups
Faith-based communities
State senators
County officials
City councils
Universities
Large area employers (HR reps)
Occupational health nurses
Economic development departments
County attorneys
Law enforcement
Water authorities
Child protective services
Boards of health
Food safety inspe3ctors
USDA
Nebraska DHHS, CIA/Asbestos inspectors
EMS/first responders
Building inspectors
Animal control officers
Veterinarians
Family planning clinics
WIC
Federally qualified health centers
Rural clinics
Social workers
Assisted living and nursing homes
Special populations
Case coordinators
Early Development Network
Dentists
Risk Managers
State staff

About 40 individuals from a cross-section of the above groups attended the daylong event. The LPHS assessment process was especially well-received. It involved touch-screen audience response technology advancements incorporated with a PowerPoint presentation using the local public health system performance assessment instrument from the National Public Health Performance Standards Program. The results of the LPHSA are listed below:

Essential Service #1: ***Monitor health status to identify community health problems***	No	Minimal	Moderate	Significant	Optimal
Has the local public health system conducted a community health assessment?				•	
Is the community health assessment updated at least every 3 years?				•	
Is data from the assessment compared to the data from other representative areas or populations?				•	
Is data used to track trends over time?				•	
Does the local public health system use data from community health assessments to monitor progress toward health-related objectives?				•	
Does the local public health system compiles data from the community health assessments into a community health profile (CHP)?				•	
Do Community Health Profile Data elements include community demographic characteristics?					•
Do Community Health Profile Data elements include community socioeconomic characteristics?					•
Do Community Health Profile data elements include health resource availability data:				•	
Do Community Health Profile data elements include quality of life data for the community?				•	
Do Community Health Profile data elements include behavioral risk factors for the community?					•
Do Community Health Profile data elements include community environmental health indicators?					•
Do Community Health Profile data elements include social and mental health data?					•
Do Community Health Profile data elements include maternal and child health data?					•
Do Community Health Profile data elements include death, illness and/or injury data?					•
Do Community Health Profile data elements include communicable disease data?					•
Do Community Health Profile data elements include sentinel events data for the community?		•			
Has the local public health system identified the individuals or organizations responsible for contributing data and/or resources to produce the Community Health Profile?			•		
Is community-wide use of community health assessment or Community Health Profile data promoted?		•			

Essential Service #1: ***Monitor health status to identify community health problems***	No	Minimal	Moderate	Significant	Optimal
Is a media strategy in place to promote community-wide use of the Community Health Profile?		•			
Is the information easily accessible by the general public?		•			
Do organizations in the local public health system use the Community Health Profile to inform health policy and planning decisions?			•		
Does the local public health system use state-of-the-art technology to support health profile databases?				•	
Is technology utilized to make community health data available electronically?				•	
Does the local public health system have access to geocoded health data?				•	
Does the local public health system use Geographic Information Systems (GIS)?				•	
Does the local public health system use computer-generated graphics to identify trends and/or compare data by relevant categories (i.e. race, gender, age group)?				•	
Does the local public health system maintain and/or contribute to one or more population health registries?				•	
Are there standards for data collection?					•
Are there established processes for reporting health events to the registry or registries?				•	
In the past year, has the local public health system used information from one or more population health registries?				•	

Essential Service #2: ***Diagnose and investigate health problems and health hazards in the community***	No	Minimal	Moderate	Significant	Optimal
Is the system integrated with national and/or state surveillance systems?				•	
Does the local public health system operate or participate in surveillance system(s) designed to monitor health problems and identify health threats?				•	
Is the system integrated with national and/or state surveillance systems?				•	
Is the system compliant with national and/or state health information exchange guidelines?				•	
Does the local public health system use the surveillance system(s) to monitor changes in the occurrences of health problems and hazards?				•	
Do community health professionals submit reportable disease information in a timely manner to the state or local public health system?					•
Does the local public health system have necessary resources to support health problems and health hazard surveillance and investigative activities?			•		
Does the local public health system use information technology for surveillance activities (e.g., geographic information systems, word pressing, spreadsheets, database analysis and graphic presentation software)?				•	
Does the local public health system have (or have access to) Masters or Doctoral level epidemiologists and/or statisticians to assess, investigate and analyze public health threats and health hazards?				•	
Does the local public health system maintain written protocols for implementing a program of case finding, contract tracing, source identification and containment for communicable diseases or toxic exposures?				•	
Are protocols in place for animal control?				•	
Are protocols in place for vector control?				•	
Are protocols in place for exposure to food-borne illness?				•	
Are protocols in place for exposure to water-borne illness?				•	
Are protocols in place for excessive lead levels?				•	
Are protocols in place for exposure to asbestos?				•	
Are protocols in place for exposure to other toxic chemicals?				•	
Are protocols in place for communicable diseases?				•	
Does the local public health system have current epidemiological case investigation protocols to guide immediate investigations of public health emergencies?				•	
Do these protocols address infectious disease outbreaks?				•	
Do these protocols address environmental health hazards and emergencies?				•	
Do these protocols address chemical threats and incidents?				•	
Do these protocols address biological agent threats?				•	
Do these protocols address radiological threats?				•	

Essential Service #2: ***Diagnose and investigate health problems and health hazards in the community***	No	Minimal	Moderate	Significant	Optimal
Do these protocols address large-scale natural disasters?				•	
Has the local public health system designated individuals to serve as an Emergency Response Coordinator within the jurisdiction?					•
Does the individual coordinate with the local health department's emergency response personnel?					•
Does the individual coordinate with local community leaders?					•
Can local public health system personnel rapidly respond to natural and intentional disasters?				•	
Does the local public health system maintain a current roster of personnel with the technical expertise to respond to natural and intentional emergencies and disasters?				•	
Does the local public health system have access to response personnel within one hour?				•	
Does the local public health system have capacity to mobilize sufficient numbers of trained professionals in an emergency (i.e., surge capacity)?				•	
Does the local public health system have capacity to mobilize volunteers during a disaster?				•	
Does the local public health system evaluate public health emergency response incidents for effectiveness and opportunities for improvement (e.g. After Action Reports)?				•	
Are findings incorporated into emergency plans?				•	
Does the local public health system maintain ready access to laboratories capable of meeting routine diagnostic and surveillance needs?				•	
Does the local public health system have ready access to laboratory services to support investigations of public health threats, hazards and emergencies?				•	
Does the local public health system have access to laboratory services to support these investigations within four hours of notification?				•	
Does the local public health system have access to at least one microbiology laboratory within four hours of notification?				•	
Does the local public health system utilize only laboratories that are licensed and/or credentialed?				•	
Does the local public health system maintain current guidelines or protocols for handling laboratory samples?				•	

Essential Service #3: ***Inform, educate and empower individuals and communities about health issues***	No	Minimal	Moderate	Significant	Optimal
Does the local public health system provide the general public, policymakers, public and private stakeholders with information on community health?				•	
Does the local public health system provide information on community health status (e.g. heart disease rates, cancer rates, environmental risks)?				•	
Does the local public health system provide information on community health needs such as those identified by members of the community or through a needs assessment tools such as APEXPH or MAPP, including prevention and risk (e.g. obesity, smoking, etc.)?				•	
Does the local public health system plan and conduct health education and/or health promotion campaigns?				•	
Are these campaigns based on sound theory, evidence of effectiveness and/or best practice?				•	
Are campaigns designed to support healthy behavior among individuals and their communities?				•	
Are campaigns tailored for populations with higher risk of negative health outcomes?			•		
Are campaigns designed to reach populations in specific settings?			•		
Does the local public health system evaluate health education and health promotion activities on an ongoing basis?				•	
Are evaluation results used to revise and strengthen the programs?				•	
Do local public health system organizations work together to plan, conduct and implement health education and promotion activates?				•	
Do organizations work together on specific health promotion activities (e.g. supermarkets and nutrition interventions)?				•	
Have local public health system organizations developed health communication plans?				•	
Do local public health system organizations work collaboratively to link the communication plans?				•	
Do the communications plans include policies and procedures for creating, sharing and disseminating information with partners and key stakeholders?				•	
Do the communications plans identify different sectors of the population in order to create targeted public health messages for various audiences?				•	
Do the communications plans provide guidance for developing content and materials appropriate to the type of dissemination channel?				•	
Do the communications plans provide guidance for creating targeted public health messages using various channels?			•		
Does the local public health system establish and utilities relationships with the media?				•	
Does the local public health system have policies and procedures in place to route all media inquiries appropriately?				•	
Does the local public health system have a mechanism in place to document and respond to public inquiries?				•	

Essential Service #3: ***Inform, educate and empower individuals and communities about health issues***	No	Minimal	Moderate	Significant	Optimal
Does the local public health system coordinate with the local media to develop information or features on health issues?				•	
Has the local public health system identified and designated individuals such as public information officers to provide important health information and answers to public and media inquiries?				•	
Are designated spokespersons adequately trained in providing accurate, timely and appropriate information on public health issues for different audiences?				•	
Does the local public health system have policies and procedures in place to coordinate responses and public announcements related to public health issues?				•	
Has the local public health system developed emergency communications plans(s) that can be adapted to defend types of emergencies (.e. disease outbreaks, natural disasters, bioterrorism)?				•	
Does the plan include procedures for inter-agency coordination of plans dependent upon the type of emergency (i.e. use of the plans to create a unified emergency communications plan?				•	
Does the plan include established lines of authority, reporting and responsibilities for emergency communications teams in accordance wit the National Incident Management System (NIMS)?				•	
Does the plan include procedures for alerting communities, including special populations, about possible health threats or disease outbreaks?				•	
Does the plan include guidelines for providing necessary, appropriate information from emergency operation ce3nter situation reports, health alerts and meeting notes to stakeholders, partners and the community?				•	
Does the local public health system have resources to ensure rapid communications response?				•	
Does the local public health system have the technological capacity (e.g. telephone, electronic and print) to respond to communication needs?				•	
Doe the local public health system have staff to develop or adapt emergency communications materials and to provide communications for all stakeholders and partners in the event of an emergency?				•	
Does the local public health system provide crisis and emergency communications training for new and current staff?				•	
Does the local public health system have policies and procedures in place to ensure rapid, mobile response by public information officers?				•	
Does the local public health system maintain a directory of emergency contact information for media liaisons, partners, stakeholders and public information officers?				•	
Does the local public health system provide communication "Go Kits" to assist in public information officer response?				•	

Essential Service #4: ***Mobilize community partnerships to identify and solve health problems***	No	Minimal	Moderate	Significant	Optimal
Does the local public health system have a process for identifying key constituents or stakeholders?				•	
Does the local public health system maintain a current list of the names and contact information for individuals and key constituent groups?			•		
Are new individuals/groups identified for constituency building?			•		
Are key constituents identified for general health issues (i.e. improved health and quality of life at the community level)?			•		
Are key constituents identified for specific health concerns (i.e. a particular health theme, disease, risk factor, life stage need)?			•	•	
Does the local public health system encourage the participation of constituents in improving community health?				•	
Does the local public health system encourage constituents from the community-at-large to identify community issues and themes through a variety of means?			•		
Does the local public health system support, through recruitment, promotion and retention, opportunities for volunteers to help in community health improvement projects or activities?				•	
Does the local public health system maintain a current directory of organizations that comprise the local public health system?				•	
Is the directory easily accessible?			•		
Does the local public health system use communications strategies to build awareness of the importance of public health?				•	
Do communications strategies exist for building awareness with the community at large?'				•	
Do communications strategies exist for facilitating communication among organizations?				•	
Do partnerships exist in the community to maximize public health improvement activities?				•	
Do organizations within these partnerships exchange information?				•	
Do organizations within these partnerships alter or align activities related to the Essential Public Health Services?				•	
Do organizations within these partnerships conduct collaborative decision-0making and action?				•	
Do organizations within these partnerships optimize resources to deliver Essential Public Health Services?				•	
Do organizations within these partnerships share responsibilities to deliver Essential Public Health Services?				•	
Do organizations within these partnerships include a broad representation of the community?				•	
Does the local public health system have a broad-based community health improvement committee?			•		
Does this partnership participate in the community health assessment process?				•	
Does this partnership participate in the implementation of a community health improvement process?				•	
Does this partnership monitor and evaluate progress toward			•	•	

Essential Service #4: ***Mobilize community partnerships to identify and solve health problems***	No	Minimal	Moderate	Significant	Optimal
prioritized goals?					
Does this partnership leverage community resources?				•	
Does this partnership meet on a regular basis?				•	
Does the local public health system review the effectiveness of community partnerships and strategic alliances developed to improve community health?			•		
Does the review include an assessment of the effectiveness of partnership participation in solving health problems?			•		
Does the review include information on the satisfaction of constituents with partnership efforts?		•			
Does the review include an assessment of the expertise and system capacity needed to conduct partnership building activities?		•			
Does the review include identification of actions to improve the partnership process and capacity?		•			
Does the review include implementation of actions recommended to improve the partnership process and capacity?		•			

Essential Service #5: ***Develop policies and plans that support individual and community health efforts***	No	Minimal	Moderate	Significant	Optimal
Does the local public health system include a governmental local public health presence (i.e. local health department) to assure the provision of Essential Public Health Services to the community?					•
Does the local health department maintain current documentation describing its mission?					•
Does the local health department maintain current documentation describing its statutory, chartered and/or legal responsibilities?					•
Does the local health department assess its functions against the operational definition of a functional local health department?					•
Does the local public health system assure the availability of resources for the local health department's contributions to the Essential Public Health Services?					•
Do recourses for the local health department include availability of legal counsel on issues related to the provision of Essential Public Health Services?					•
Do resources for the local health department include funding for mandated public health programs?					•
Do resources for the local health department include funding for needed public health programs, as identified by the community?				•	
Do resources for the local health department include the personnel required to deliver Essential Public Health Services including a designated local health official?					•
Do resources for the local health department include the facilities, equipment and supplies required to deliver Essential Public Health Services?				•	
Does a local board of health or other governing entity conduct oversight for the local health department?					•
Has this local board of health or other governing entity completed the National Public Health Performance Standards Program's Local Public Health Governance Assessment instrument?				•	
Does the local health department work with the state public health agency and other state partners to assure the provision of public health services?					•
Have state partners completed the National Public Health Performance Standards Program's State Public Health System Performance Assessment Instrument with input from the local level?				•	
Does the local public health system contribute to the development of public health policies?					•
Does the local public health system engage constituents in identifying and analyzing issues?					•
Does the local public health system advocate for prevention and protection policies for those in the community who bear a disporportio0nate risk for mortality and morbidity?				•	
Within the past year, has the local public health system been involved in activities that influenced or informed the public health policy process?					•
Does the local public health system alert policymakers and the public of public health impacts from current and/or proposed policies?				•	

Essential Service #5: ***Develop policies and plans that support individual and community health efforts***	No	Minimal	Moderate	Significant	Optimal
Does the local public health system review public health policies at least every three to five years?				•	
Do reviews include assessment of outcomes and/or consequences?				•	
Do reviews include examination of potential community health impact of other policy areas (e.g. fiscal, social, environmental)?				•	
Do review processes include community constituents, including those affected by the policy?				•	
Has the local public health system established a community health improvement process (e.g. MAPP, PACE EH)?					•
Did the community health improvement process use an established tool such as MAPP or PACE-EH?					•
Is there broad participation in the community health improvement process?				•	
Does the process include information from community health assessments?				•	
Does the process include issues and themes identified by the community?				•	
Does the process include identification of community assets and resources?				•	
Does the process include prioritization of community health issues?					•
Does the process include development of measurable health objectives?				•	
Does the process result in the development of a community health improvement plan?				•	
Is the community health improvement plan linked to a state health improvement plan?			•		
Have the individuals or organizations accountable for the implementation of these strategies been identified?				•	
Does the local health department conduct a strategic planning process?					•
Does the local health department review its organizational strategic plan to determine how it can best be aligned with the community health improvement process?				•	
Do local public health system organizations participate in a task force or coalition of community partners to develop and maintain local and/or regional emergency preparedness and response plans?				•	
Does task force participation include broad representation from the local public health system?				•	
Does the local public health system have an all-hazards emergency preparedness and response plan?					•
Does the plan identify public health disasters and emergencies that might trigger its implementation?					•
Does the plan align with existing plans, protocols and procedures for emergency response within the community?					•
Does the plan clearly outline protocols and standard operating procedures for emergency response?				•	
Has the all-hazards plan been reviewed and, if appropriate, revised within the past two years?					•

Essential Service #5: ***Develop policies and plans that support individual and community health efforts***	No	Minimal	Moderate	Significant	Optimal
Has any part of the plan been tested through simulation of one or more "mock events" within the past two years?					•
Did the mock event include a written after-action report identifying opportunities for improvement?					•
Was the plan modified based on these findings?				•	

Essential Service #6: ***Enforce laws and regulations that protect health and ensure safety***	No	Minimal	Moderate	Significant	Optimal
Does the local public health system identify local public health issues that can only be addressed through laws, regulations and ordinances?				•	
Is the local public health system knowledgeable about federal, state and local laws, regulations and ordinances that protect the public's health?				•	
Does the local public health system review the laws, regulations and ordinances that protect public health at least once every five years?			•		
Do reviews determine whether laws, regulations and ordinances provide the authority to carry out the Essential Public Health Services?			•		
Do reviews assess compliance with public health laws, regulations and ordinances?			•		
Do reviews determine the impact of existing laws, regulations and ordinances on the health of the community?				•	
Do reviews determine whether public health laws, regulations and ordinances require updating?			•		
Do governmental entities within the local public health system have access to legal counsel to assist with the review of lawks regulations and ordinances related to the public's health?					•
Doe the local public health system identify local public health issues that are not adequately addressed through existing laws, regulations and ordinances?				•	
Within the past five years, have local public health system organizations participated in the development or modification of laws, regulations or ordinances for public health issues that are not adequately addressed through existing laws, regulations and ordinances?				•	
Do local public health system organizations provide technical assistance to legislative, regulatory or advocacy groups for drafting proposed legislation, regulations or ordinances?				•	
Do governmental public health entities within your local public health system have the authority to enforce laws, regulations or ordinances related to the public's health?				•	
Does a document (paper or electronic) exist that identifies the roles and responsibilities of each governmental entity with enforcement authority?			•		
Do governmental entities with enforcement authority provide their staff who engage in or support enforcement activities, with formal training on compliance and enforcement?				•	
Is the local health department or governmental public health entity empowered through laws and regulations to implement necessary community interventions in the event of a public health emergency?				•	
Does this entity's authority include power to implement quarantine and isolation?					•
Does this entity's authority include power to implement mass immunization and dispensing clinics?					•
Does the local public health system assure that all enforcement				•	

Essential Service #6: ***Enforce laws and regulations that protect health and ensure safety***	No	Minimal	Moderate	Significant	Optimal
activities are conducted in accordance with applicable laws, regulations and ordinances?					
Does the local public health system have the appropriate power and ability to prevent, detect, manage and contain emergency health threats?				•	
Does the local public health system conduct enforcement activities within the time frame stipulated in laws, regulations or ordinances?				•	
Does the local public health system conduct enforcement activities in compliance with due process and civil rights protections?				•	
Does the local public health system provide information about public health laws, regulations and ordinances to the individuals and organizations who are required to comply with them?				•	
Is dissemination of this information integrated with other public health activities (e.g. health education, communicable disease control, health assessment, planning)?				•	
In the past five years, has the local public health system assessed the compliance of institutions and businesses in the community (e.g. schools, food establishments, day care facilities) with laws, regulations and ordinances designed to ensure the public's health?				•	
Did the assessment include input from the regulated institutions and business regarding their perceived difficulties with compliance?			•		
Did the assessment examine enforcement activities by regulated institutions and businesses?			•		
Did the assessment include input from key stakeholders (other than the regulated institutions and businesses) of those laws, regulations and ordinances regarding the extent of their support of enforcement activities?		•			

Essential Service #7: ***Link people to needed health services and assure the provision of health care when otherwise unavailable.***	No	Minimal	Moderate	Significant	Optimal
Does the local public health system identify any populations who may experience barriers to personal health services?				•	
Has the local public health system identified the personal health service needs of populations in is jurisdiction?			•		
Have personal health service needs been identified for populations who may experience barriers to care?			•		
Has the local public health system assessed the extent to which personal health services in its jurisdiction are available to populations who may experience barriers to care?			•		
Has the local public health system assessed the extent to which personal health services are utilized by populations who may experience barriers to care?			•		
Does the local public health system link populations to needed personal health services?			•		
Does the local public health system provide assistance to vulnerable populations in accessing needed health services?			•		
Does this assistance include culturally and linguistically appropriate staff to assist population groups in obtaining personal health services?			•		
Does this assistance include culturally and linguistically appropriate materials?			•		
Does this assistance include transportation services for those with special needs?		•			
Does the local public health system have initiatives to enroll eligible individuals in public benefit programs such as Medicaid and/or other medical or prescription assistance programs?			•		
Does the local public health system coordinate the delivery of personal health and social services to optimize access to services for populations who may encounter barriers to care?			•		
Are services targeting the same populations co-located to optimize access?		•			
Are services targeting the same populations coordinated among providers to optimize access?		•			

Essential Service #8: ***Assure a competent public and personal health care workforce***	No	Minimal	Moderate	Significant	Optimal
Within the past three years, has an assessment of the local public health system workforce been conducted?			•		
Whether or not a formal assessment has been conducted, have shortfalls and/or gaps within the local public health system workforce been identified?				•	
Were gaps related to workforce composition identified?				•	
Were gaps related to workforce size identified?			•		
Were gaps related to workforce skills and/or experience identified?				•	
Were recruitment and retention shortfalls identified?				•	
Is this knowledge used to develop plans to address workforce gaps?				•	
Have the organizations within the local public health system implemented plans for correction?				•	
Is there a formal process to evaluate the effectiveness of plans to address workforce gaps?			•		
Were the results of the workforce assessment and/or gap analysis disseminated for use in local public health system organizations' strategic or operational plans?				•	
Was the information provided to community leaders?			•		
Was the information provided to governing bodies?		•			
Was the information provided to public agencies?				•	
Was the information provided to elected officials?		•			
Are organizations within the local public health system aware of guidelines and/or licensure/certification requirements for personnel contributing to the Essential Public Health Services?				•	
Are organizations within the local public health system in compliance with guidelines and/or licensure/certification requirements for personnel contributing to the Essential Public Health Services?				•	
Have organizations within the local public health system developed written job standards and/or position descriptions for all personnel contributing to the Essential Public Health Services?				•	
Do organizations within the local public health system conduct annual performance evaluations?				•	
Does the local health department develop written job standards and/or position descriptions for all personnel?				•	
Are job standards and/or position descriptions reviewed periodically?				•	
Does the local health department conduct performance evaluations?				•	
Does the local public health system identify education and training needs so as to encourage opportunities for workforce development?				•	
Is workforce development encouraged and/or provided through distance learning technology?				•	
Is workforce development encouraged and/or provided through national, state, local and regional conferences?				•	
Is workforce development encouraged and/or provided through staff cross-training?			•		

Essential Service #8: ***Assure a competent public and personal health care workforce***	No	Minimal	Moderate	Significant	Optimal
Is workforce development encouraged and/or provided through coaching, mentoring and modeling?			•		
Does the local public health system provide refresher courses for key public health issues (e.g. HIPAA, non-discrimination and emergency preparedness)?			•		
Does the local public health system provide opportunities for all personnel to develop core public health competencies?				•	
Do these training opportunities include an understanding of the Essential Public Health Services?		•			
Do these training opportunities include an understanding of the multiple determinants of health to develop more effective public health interventions?				•	
Do these training opportunities include cultural competence to interact with colleagues and community members?			•		
Are incentives provided to the workforce to participate in educational and training experiences?				•	
Does the local health department have dedicated resources for training and education?					•
Are there opportunities for interaction between staff of local public health system organizations and faculty from academic and research institutions, particularly those connected with schools of public health?			•		
Do organizations within the local public health system promote the development of leadership skills?				•	
Is leadership skill development promoted by encouraging potential leaders to attend formal leadership training?				•	
Is leadership skill development promoted by mentoring personnel in middle management/supervisory positions?			•		
Is leadership skill development promoted by promoting leadership at all levels within organizations that comprise the local public health system?			•		
Is leadership skill development promoted by establishing financial resources to support leadership development on an ongoing basis?			•		
Do organizations within the local public health system promote collaborative leadership through the creation of a shared vision and participatory decision-making?					•
Across the local public health system organizations, are ether established communication mechanisms that encourage informed participation in decision-making (e.g. forums, list servs)?					•
Does the local public health system provide leadership with opportunities for individuals and/or organizations in areas where their expertise can provide insight, direction or resources?				•	
Does the local public health system recruit and retain new leaders who are representative of the population diversity within their community?			•		
Does the local public health system provide opportunities to develop community leadership through coaching and mentoring?			•		

Essential Service #9: ***Evaluate effectiveness, accessibility and quality of personal and population-based health services***	No	Minimal	Moderate	Significant	Optimal
In the past three years, has the local public health system evaluated population-based health services?				•	
Are established criteria used to evaluate population-based health services?				•	
Does the evaluation determine the extent to which program goals are achieved for population-based health services?				•	
Does the local public health system assess community satisfaction with population-based health services?			•		
Does the assessment gather input from residents representing a cross-section of the community?				•	
Doe the assessment determine if residents' needs are being met, including those groups at increased risk of negative health outcomes?				•	
Doe the assessment determine resident's satisfaction with the responsiveness to their complaints or concerns regarding population-based health services?				•	
Does the assessment identify areas where population-based health services can be improved?				•	
Does the local public health system identify gaps in the provision of population-based health services?				•	
Do organizations within the local public health system use the results of population-based health services evaluation in the development of their strategic and operational plans?				•	
In the past three years, have organizations within the local public health system evaluated personal health services for the community?				•	
Were the following assessed: access to personal health services?				•	
Were the following assessed: the quality of personal health services?				•	
Were the following assessed: the effectiveness of personal health services?				•	
Are specific personal health services in the community evaluated against established standards (e.g. JVAHO, state licensure, HEDIS)?			•		
Does the local public health system assess client satisfaction with personal health services?				•	
Were surveyed clients representative of past, current and potential users of services?				•	
Do organizations within the local public health system use information technology to assure quality of personal health services?				•	
Do organizations use electronic health records?					•
Is information technology used to facilitate communication among providers (e.g. Health Information Exchange or Regional Health Information Organizations)?				•	
Do organizations within the local public health system use the results of the evaluation in the development of their strategic and operational plans?				•	
Has the local public health system identified community organizations or entities that contribute to the delivery of the Essential Public Health Services?				•	

Essential Service #9: ***Evaluate effectiveness, accessibility and quality of personal and population-based health services***	No	Minimal	Moderate	Significant	Optimal
Is an evaluation of the local public health system conducted every three to five years?				•	
Does the evaluation assess the comprehensiveness sofa the local public health system activities?				•	
Does the evaluation use established standards (e.g. National Public Health Performance Standards Program)?				•	
Do the local public health system entities participate in the evaluation of the local public health system?				•	
Has a partnership assessment been conducted that evaluates the relationship among organizations that comprise the local public health system (e.g. the NPHPSP or an evaluation of a partnership within the MAPP process)?				•	
Is the exchange of information among the organizations in the local public health system assessed?			•		
Are linkage mechanisms among the providers of population-based services and personal health services assessed (e.g. referral systems, memoranda of understanding)?			•		
Is the use of resources (e.g. staff, communication system) to support the coordination among local public health system organizations assessed?			•		
Does the local public health system use results from the evaluation process to guide community health improvements?				•	
Are the results from the evaluation process used to refine existing community health programs?				•	
Are the results from the evaluation process used to establish new community health programs?				•	
Are the results from the evaluation process used to redirect resources?				•	
Are the results from the evaluation process used to inform the community health improvement process?				•	

Essential Service #10: ***Research for new insights and innovative solutions to health problems***	No	Minimal	Moderate	Significant	Optimal
Do local public health system organizations encourage staff to develop new solutions to health problems in the community?				•	
Do local public health system organizations provide time and/or resources for staff to pilot test or conduct studies to determine new solutions?			•		
During the past two years, have local public health system organizations proposed to research organization one or more public health issues for inclusion in their research agenda?		•			
Do local public health system organizations identify and stay current with best practices developed by other public health agencies or organizations?				•	
Do local public health system organizations encourage community participation in the development or implementation of research?			•		
Doe the local public health system develop relationships with institutions of higher learning and/or research organizations?				•	
Does the local public health system partner with at least one institution of higher learning and/or research organizations to conduct research related to the public's health?			•		
Does the local public health system encourage collaboration between the academic and practice communities?				•	
Does the local public health system have access to researchers (either on staff or through other arrangements)?		•			
Is there access to resources to facilitate research within the local public health system?			•		
Doe the local public health system disseminate findings from their research?		•			
Doe the local public health system evaluate its research activities?			•		
Doe the local public health system evaluate the development of research activities?		•			
Does the local public health system evaluate the implementation of research activities?		•			
Does the local public health system evaluate the impact of research activities on public health practice?		•			
Does the local public health system evaluate the involvement of community representatives in collaborative research efforts (i.e. community-based participatory research)?		•			

Community Themes & Strengths

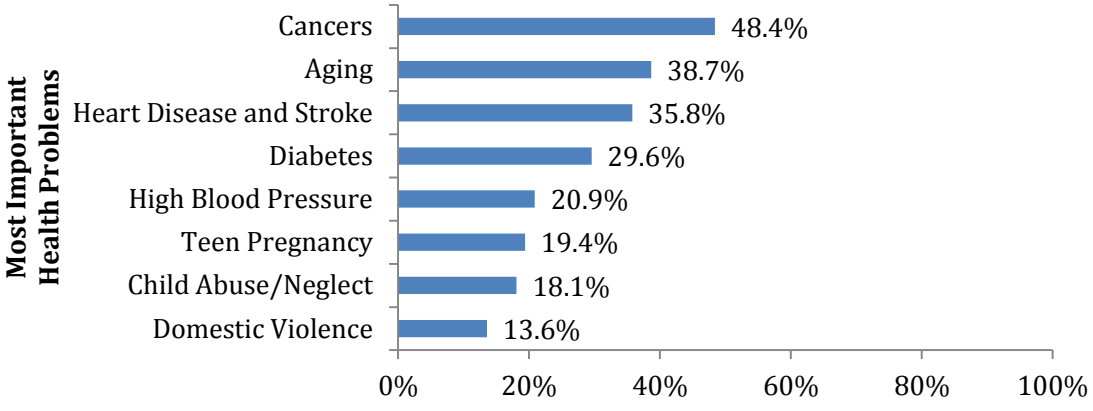
In 2011, PPHD and SBCHD surveyed 11 Counties in the Panhandle. The replies from 564 respondents are included below.

Survey Data

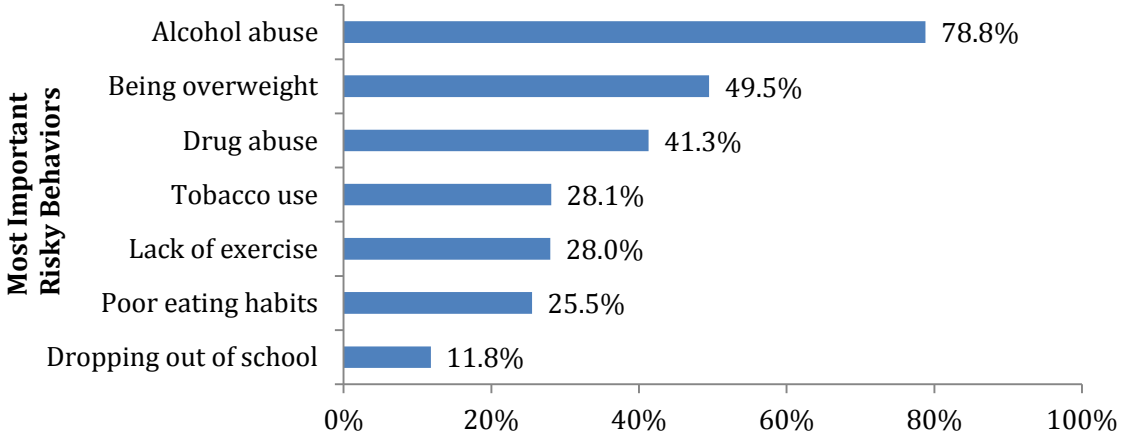
Question	Very Unhealthy	Unhealthy	Somewhat Unhealthy	Healthy	Very Healthy
1. How would you rate your community as a "Healthy Community?"	0.9	9.6	51.6	36.2	1.8
2. I am satisfied with the quality of life in our community (considering my sense of safety and well-being)	0.7	8.1	18.6	60.5	12.1
3. I am satisfied with the health care system in our community	3.1	14.2	23.2	49.9	9.5
4. I have easy access to the medical specialists that I need.	2.9	18.9	22.5	47.2	8.5
5. I am very satisfied with the medical care I receive.	1.6	7.9	24.0	53.5	13.0
6. Sometimes it is a problem for me to cover my share of the cost for a medical care visit.	7.4	29.7	20.0	33.7	9.2
7. I am able to get medical care whenever I need it.	2.3	12.3	14.2	60.4	10.8
8. This community is a good place to raise children	0.5	3.3	14.9	51.6	29.7
9. I have access to safe and affordable day care	1.4	3.8	63.4	21.4	10.0
10. I am very satisfied with the school system in my community	2.2	13.6	29.0	39.3	15.9
11. There are adequate after school programs for elementary age children to attend.	4.2	17.4	40.4	30.6	7.4
12. There are adequate after school opportunities for middle and high school age students.	5.8	27.7	39.9	23.4	3.3
13. There are plenty of recreation opportunities for children in my community.	7.6	29.7	30.4	29.2	3.1
14. This community is a good place to grow old (considering elder-friendly housing, transportation to medical services, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)	2.7	15.4	21.4	52.8	7.7
15. There are housing developments that are elder friendly.	1.5	16.1	26.9	48.4	7.1
16. There is a transportation service that takes older adults to medical facilities or to shopping centers.	2.4	8.6	18.3	57.0	13.7
17. There are enough programs that provide meals for older adults in my community	2.0	11.3	33.1	47.2	6.4

Question	Very Unhealthy	Unhealthy	Somewhat Unhealthy	Healthy	Very Healthy
18. There are networks for support for the elderly living alone.	2.0	18.8	47.3	29.1	2.7
19. There are jobs available in the community (considering locally owned and operated businesses, jobs with career growth, affordable housing, reasonable commute, etc.)	11.6	32.3	22.3	31.9	1.8
20. There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher opportunities).	9.0	36.5	31.2	21.8	1.5
21. The community is a safe place to live (considering residents' perception of safety in the home, the workplace, schools, playgrounds, parks, shopping areas). Neighbors know and trust one another and look out for one another.	0.9	5.2	11.6	64.0	18.3
22. There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need.	0.6	9.8	19.7	61.3	8.7
23. All residents believe that they, individually and collectively, can make the community a better place to live.	2.0	21.8	31.9	41.0	3.3

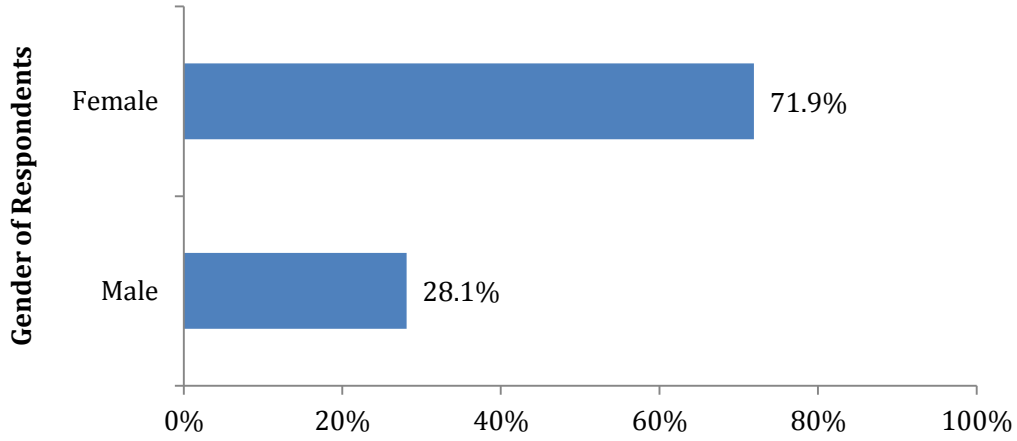
24. What do you think are the three most important "health problems" in our community? (problems that have the greatest impact on overall community health). Top ranking categories were:



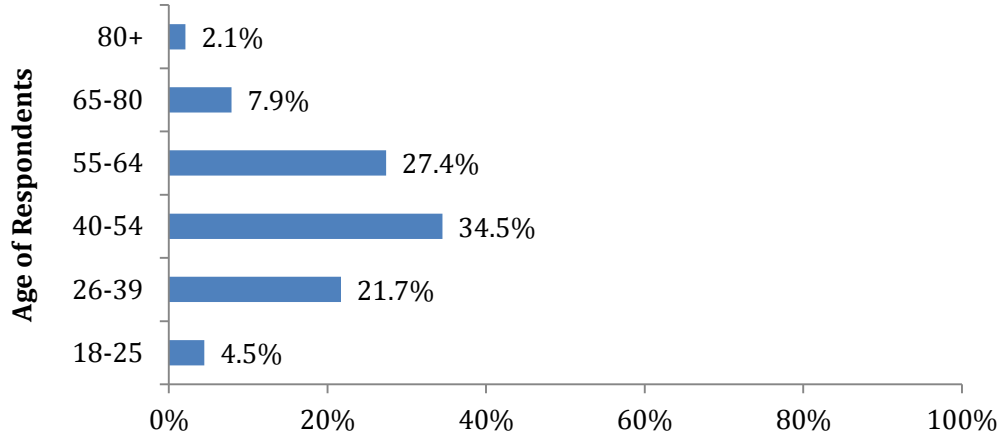
25. In the following list, what do you think are the 3 most important "risky behaviors" in our community? (those behaviors that have the greatest impact on overall community health)



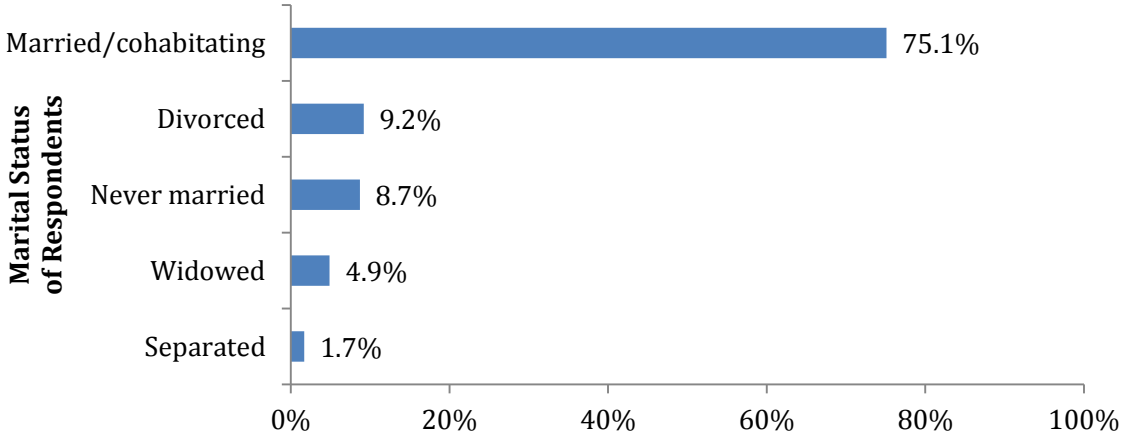
26. What is your gender?



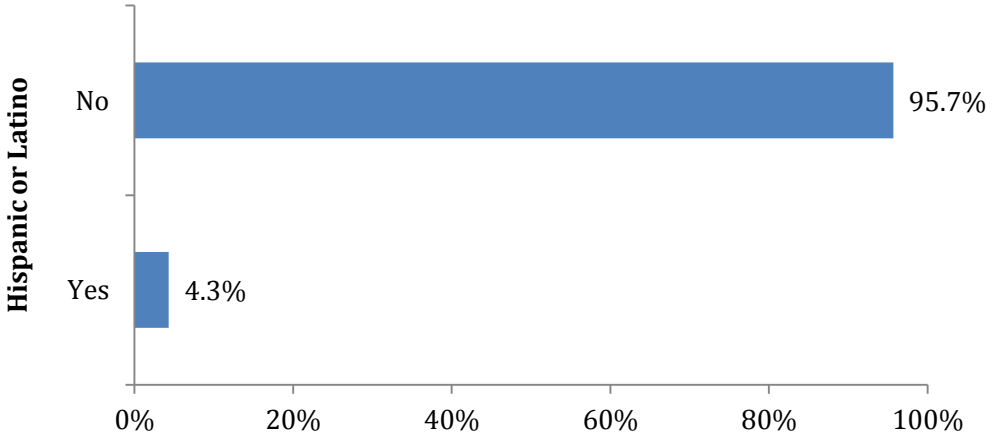
27. Your age?



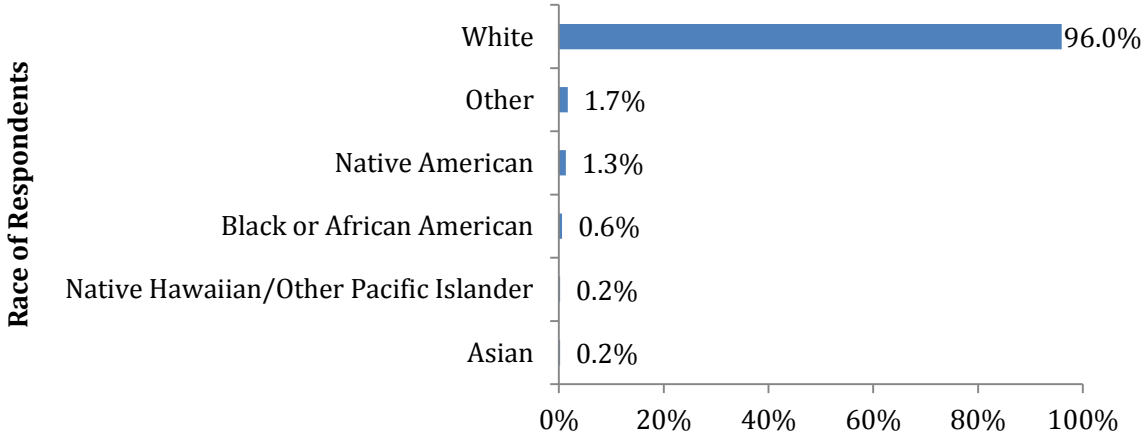
28. Marital Status?



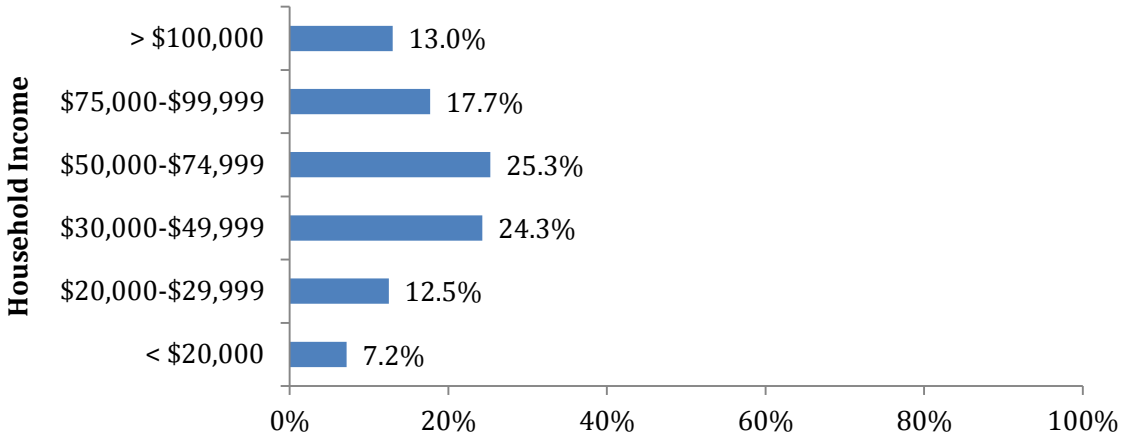
29. Are you Hispanic or Latino?



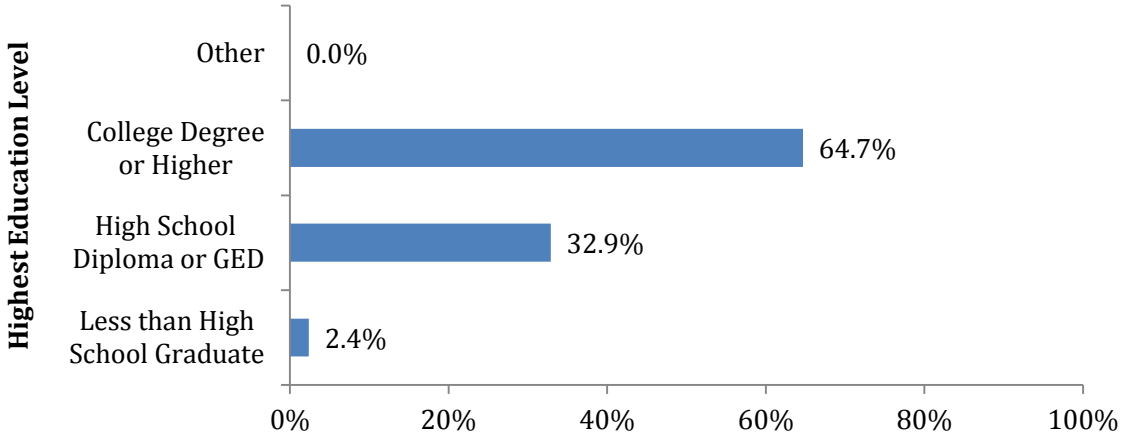
30. Which one of these groups would you say best represents your race?



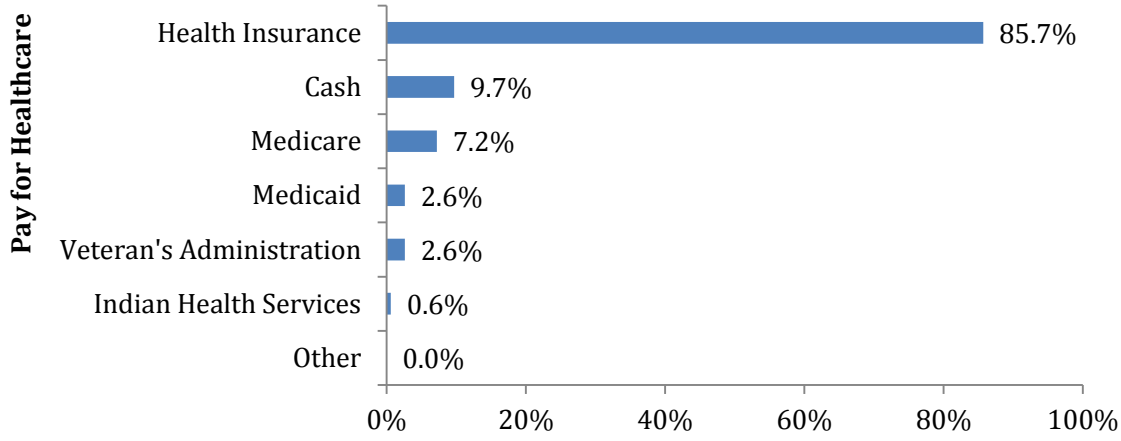
31. Household income?



32. Your highest education level?



33. How do you pay for your health care?



Community Dialogue and Participation: Special Focus Groups and Surveys Summary

Additional information was solicited from community members. Fourteen community focus groups were held in seven of the counties. An average of 6-8 citizens participated in each group. In addition two youth focus groups in were held, one in Sheridan County and one in Morrill County. Native American community members in Dawes, Sheridan, and Scottsbluff Counties and Hispanic community members in Box Butte County also participated in focus groups.

Community Description

- *The majority of comments in the Community focus groups noted the attributes of the area (space, geography, low population, helpful, hardworking, good place to raise family.*
- *On the other hand Youth and Native American focus groups had a less positive view of the community. Youth focused on the social structure of the community (e.g. cliques, gossip, boring) and the ambiance (run down, dwindling, close).*
- *Native American community members focused on socio economic issues (lack of jobs, poor housing, lack of transportation), social issues (prejudice, increased violence, environmental issues, and danger) and services (poor healthcare services, lack of Native American run recreation and youth programs).*

Community Strengths

- *All focus groups noted the land (farm land, state parks, lakes, city parks) as an asset.*

Community Changes in Past Five Years

- *Youth and Native American focus groups noted increases in violence, poverty, drug and alcohol use.*
- *All noted the number of services and resources that have diminished (grocery stores, entertainment, numbers of doctors, school districts combining, less industry).*

What is lacking in the community?

- *All groups concurred on jobs, housing, businesses, services /restaurants, health care providers, counseling services, recreation and entertainment for young people.*

Interactions between Community Members from Different Backgrounds

- *All groups noted levels of prejudice between people of different backgrounds (race, economic levels, sexual orientation, family groups, ages).*
- *Inequity of law enforcement was noted by youth and Native American groups.*

Most Needed

- *Jobs with health benefits, homes to rent, recreation for youth.*

Summit for a Healthy Panhandle

In July 2011 over 150 people participated in this daylong event. Small group breakout sessions and individual evaluations and response pages noted the following:
*Influential Factors***:**

Asked to note factors that impact the data in their *work/volunteer* place participants indicated the following priority areas.

- **Economic Factors**: *Wages, Poverty and Budget Cuts*
- **Health Behaviors/Lifestyles:** *Alcohol and Drug Use, No Support for Exercise, Unhealthy Eating Habits, Mental Health concerns*.
- **Emotional/Stressors Conditions:** *Stress, Busy Schedules, Abuse, Attitudes toward Change, Shift Work.*
- **Demographics:** *Changes in Community Demographics and Single Parents*
- **Access to Health Care**: No Health Insurance

Asked the same question for their *community* participants noted:

- **Economic Factors:** *Poverty and Economic Development*
- **Health Promotion**: *Access to quality food, Access to exercise equipment/facilities, Fast Foods, Healthy Eating*
- **Community Context** *No Transportation , Health Care Availability, Racism, Acceptance of Alcohol, Justice System, Leadership ,Lack of Collaboration in Scotts Bluff County, Activities for Teens, Social Norms*
- **Motivation** *Parent Education, Attitudes, Acceptance, Initiative*

Themes for Meaningful Change

- Economic Development and Development
- Education
- Parenting
- Early Childhood Education and Early Intervention
- Family Health
- Youth Programs
- Social Supports in Community
- Mental Health
- Healthy Lifestyles

Prioritization Process

A regional meeting was held in November 2011 at the Harms Center in Scottsbluff with the MAPP stakeholders to review the assessment information gathered to date and to begin the prioritization process for the health priorities. The public health system priorities will be chosen in the first quarter of 2012.

Many important health and public health system issues surfaced during the MAPP assessments; however, it would be too difficult to address all of them. The following process was used to help choose the health priorities to add more structure to the priority selection process by incorporating both quantitative and qualitative criteria. **Health priorities** represent the health conditions and health behaviors having the greatest impact on the population. The following criteria were used choose the health priorities:

- **Magnitude or size of the problem**: Shows the number/percentage of the population involved;
- **Comparison with state results**: Compares local data with state and national data;
- **Historical trends**: Indicates whether the health issue is getting better, worse, or remaining the same;
- **Economic and social impact**: Reflects the impact on workforce productivity, health care costs, crime rates, education, and the health of the population;
- **Changeability**: Indicates whether the health issue can be influenced at the local level in the next three to five years through prevention strategies and whether there are evidence-based programs, policies, and practices available that can significantly impact the issue;
- **Capacity of the local public health system**: Reflects the skills, awareness, interest, and support by public health partners within the LHD region;
- **Readiness or political will**: Reflects the awareness, interest, and political support or lack of clear political opposition at both the state and community levels

The following spreadsheets show the health status areas chosen and the scoring process of the group gathered. Priorities chosen based on the criteria above are:

1. Improved nutrition and increased physical activity to reduce overweight and obesity, heart disease, cancer, diabetes, and many other health concerns
2. Increased cancer screenings
3. Injury and violence prevention
4. Mental health – increased access to social and emotional support

It was also recognized by the group that regional efforts currently underway that were derived at through an assessment process resulting in the selection of evidence base strategies would remain priorities for the area as well. Those include the work of the following regional coalitions: Panhandle Worksite Wellness Council, Panhandle Regional Medical Response System, Panhandle Suicide Prevention Task Force, Panhandle Cancer Coalition and Panhandle Prevention Coalition.

Vision: What do we see in place in 3-5 years as a result of our actions?								
Access	**Safer Communities**	**Compassionate Integrative Care**	**Healthy Eating Environment**	**Active Living Opportunities**	**Decreased Substance Abuse**	**Policy to Promote Healthy Environment**	**Quality of Life for All Ages**	**Educated and Informed Community**
· Affordable and accessible youth friendly health care - mental - dental - medical · Access resources all ages · All people have health insurance · Eliminate disparities · Accessible public transportation (7 days/week) · Awareness…track what works and what does not · Resources available to everyone · Increase healthy provider visits (vs sickness only visits) · Health information exchange · Public education (all levels) · Easier to self-monitor health - labs	· Reduce car crashes · Reduce suicide · Reduce child abuse · Reduce domestic violence · Neighbor-hood watch · Prevent unintentional injuries · Emergency prepared-ness	· Holistic approach - physical - mental - social · More smiles, less stress · More humanity in systems contact · Panhandle-wide beautification projects for com-munities · Focus on prevention of medical issues · Effective interpersonal relationship in service delivery	· Family gardens · Affordable healthy school lunches · Eat out healthy foods · Implementing community-wide programs to reduce obesity · Improved culture of health - better foods - walking paths - active families · Decrease childhood obesity	· Implement community-wide programming to reduce obesity · Increase physical activity/exercise · More opportunities for Activity in communities · Improved culture of health - better foods - walking paths - active families · Walking trails · Increased worksite wellness	· Reducing substance abuse (legal and illegal) · Less substance abuse · Decreased smoking · Responsible legal alcohol consumption · Prescription disposal	· Funding · Elected officials educated on “needs” · Increased taxes on tobacco, alcohol and sugary drinks · Policy development for improved health · Environments where healthy choice is easy choice	· Elderly quality of life · Engage levels of community – all ages-activities (barn dances) · Improved culture of health - better foods - walking paths - active families · Strengthen our families’ structures · Maintaining autonomy of family	· Decreased high school dropout rate · Decreased stigma about mental health · Higher graduation rate with affordable college option · Better relationship education

Forces of Change: What trends, factors and events are or will be influencing the health and safety in our Panhandle community and/or the work of the public health system?									
Geographic Challenges	**Workforce Recruitment and Retention**	**Healthy Initiatives at National and Local Level**	**Technology Changes and Challenges**	**Demographic Changes**	**Cultural Shifts**	**Economic Shifts**	**Healthcare Uncertainties**	**Panhandle Strengths**	**Intolerance**
· Distances · Cost of travel · Fuel costs	· Doctor/ nurse shortages · Shortage of pre-hospital providers · Loss of rural physicians · Mid-level providers · Decreased service resources	· Michelle Obama's push for "Let's Move" · Increased wellness · Fast foods? Obesity portions? · Increased vaccines · Veterans directed care	· Cost of technology to deliver services online, social networking · Fiber network · Access to education opportunities · Better communica-tions · Tech proliferation · Electronic health exchange	· Dichotomy of representatio n and resources distributed between East and West · Brain drain Continual "out migration" of population · Retirement of Boomers · Elderly quality of care · Aging population · Loss of population in Panhandle · School consolidation · State redistricting	· Lack of community commitment · Parental supervision · Generational patterns +/- · Inflated expectations of life (volunteer, economic, possessions, output) · Decreased self esteem · Increased poverty · Education style shift (less face to face) · Earlier sexual involvement · Agency involvement with child rearing	· Economic development · Small business closed, Wal-Mart coming in · Changes in energy production (wind, oil, bio…) · State budget, federal, local · Lack of diversified economy · Poor economy leads to rise in substance abuse · Wealth gap · Consolidation (increased networks, de-creased jobs)	· Questions about the cost for healthcare reform · Healthcare legislation · Healthcare costs · New policies · Over regulations · Decreased funding	· Continued collaborati on · Rural beliefs · Strong values, independe nce practical, forward-thinking · Multiple hats, multi-tasking · Cultural diversity	· Terrorism · School violence · Increased "hate" against others · Political extremes